NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

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

NICE guideline: full version, November 2015

Contents

Introduction

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

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

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

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

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

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

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

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

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

The Care Quality Commission (CQC) use NICE guidelines as evidence to inform the inspection process and NICE quality standards to inform ratings of good and outstanding.

Context

Legislation, policy and guidance

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

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

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

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

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

Current practice

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

In May 2013, a national collaboration co-produced 'Integrated Care and Support: Our Shared Commitment', a framework document on integration.

This continues a policy direction towards better partnership and integrated working. The document sets out how local areas can use existing structures such as health and wellbeing boards to make further steps towards integration. National Voices, a national coalition of health and care charities, developed a [person-centred 'narrative' on integration](#) with [Think Local Act Personal.](#) A further partnership created a [Memorandum of Understanding to support joint action on improving health through the home](#), setting out a shared commitment to integrated working across health, social care and housing.

The August 2013 Spending Review established the [Better Care Fund](#): a local single pooled budget to encourage the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services. Following on from the framework document the [Integrated Care and Support Pioneers Programme](#) was set up in December 2013 to test new ways to join up people's care around their needs. The first [annual report](#) sets out the experiences of the first 14 areas to take part in the programme – many of them seeking to provide integrated care and support at the interface with general hospitals.

While some localities have 'pioneer' status, all local systems are faced with tackling the challenges presented through better joined-up working across an increasingly diverse market for care and support. New models of practice are emerging, involving the independent sector as well voluntary and community services, with the aim of enabling older people to remain at home for longer. Some aim to ensure that, where care and treatment in a hospital environment is really needed, people are admitted for the shortest possible episodes. Anticipatory and advance care planning, used particularly to ensure people at the end of life can exercise choice, may also be used for people in the early stages of dementia, or who have other forms of cognitive impairment, or who are considered at greater risk of avoidable hospital admission.

Focusing on admission from care homes, analysis from the [Health Foundation](#) and Nuffield Trust highlights that care home residents are particularly at risk of emergency hospital admissions. The report of a [Serious Case Review](#) on the

Orchid View care home highlights the critical importance of engagement of service providers in preadmission assessment. It states that this should reflect their 'engagement as a key part of the whole systems approach of health and social care, hospital, residential, primary and community care'.

While statistics show a significant percentage of people in general hospitals are older people, studies suggest that other adults with care and support needs can experience disadvantage in the way they experience transition between settings. Commenting on the [evaluation report of the homeless discharge fund](#) published in January 2015, the [Chief Executive of Healthwatch England](#) used an example from their Special Inquiry on unsafe discharge to illustrate the difficulties and unequal treatment that can be faced by homeless people – whether they are experiencing street homelessness, staying in temporary housing accommodation, bedding down in hostels or on a friend's sofa. [Safely home](#) – Healthwatch England's report of the findings of the Inquiry – also considers the experience of older people and people with mental health difficulties

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

The changing landscape – new models for providing and funding care

Increasingly local systems are testing out local initiatives such as 'discharge to assess' schemes. This approach and other emerging models are described in an article by Dr Ian Philp. Following initial assessment in hospital and some short-term reablement, people can discuss their needs and aspirations for longer-term support in their home environment. Initiated to help the NHS to manage 'patient flow', interest is growing in what positive impacts there might

be on people using services and their carers and in what system or organisational change is required to scale up these local initiatives.

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

In January the NHS invited individual organisations and partnerships, including those within the voluntary sector to apply to become 'vanguard' sites for the New Care Models Programme, 1 of the first steps towards delivering the [Five-year forward view](#) and supporting improvement and integration of services. As well as breaking down the barriers in how care is provided, the chief executive's vision for the NHS recognises the need to become a better partner with voluntary organisations and local communities. The CQC has signalled its intention to adapt to reflect new ways of working across health and social care as well as older models of care. As policy, practice and funding move towards greater devolution to local level, quality assessments will aim to build a picture of what care is like for people who use a range of different services in a locality.

Person-centred care

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

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

If someone does not have capacity to make decisions, health and social care practitioners should follow the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards.

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

Recommendation wording

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

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

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

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

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.

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.

1.1.2 Identify and support people at risk of less favourable treatment or with less access to services for example, people with communication difficulties or who misuse drugs or alcohol. Support may include help to access advocacy.

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.

Communication and information sharing

1.1.4 Ensure that the person, their carers and all health and social care practitioners involved in someone's move between hospital and home are in regular contact with each other. This is to ensure the transition is coordinated and all arrangements are in place. For more on medicines-related communication and medicines reconciliation during transitions, see sections 1.2 and 1.3 in NICE's guideline on medicines optimisation and section 1.3 in NICE's guideline on managing medicines in care homes.

1.1.5   Give people information about their diagnoses and treatment and a complete list of their medicines when they transfer between hospital and home (including their care home). If appropriate, also give this to their family and carers.

1.1.6   Offer information in a range of formats, for example:

- 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 (see the Accessible Information Standard).

1.2   Before admission to hospital

1.2.1   Health and social care practitioners should develop a care plan with adults who have identified social care needs and who are at risk of being admitted to hospital. Include contingency planning for all aspects of the person's life. If they are admitted to hospital, refer to this plan.

1.2.2   If a community-based multidisciplinary team is involved in a person's care that team should give the hospital-based multidisciplinary team a contact name. Also give the named contact to the person and their family or carer.

1.2.3   Health and social care practitioners and advocates should explain to the person what type of care they might receive. See sections 1.3 and 1.5 of NICE's guideline on patient experience in adult NHS services. Discussions might cover:

- place of care
- religion, culture and spirituality
- daily routines (including the use of medicines and equipment)
- 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
- advance care plans
- contingency planning
- end-of-life care.

1.3 *Admission to hospital*

Communication and information sharing

1.3.1 Develop and use communication protocols and procedures to support admissions.

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 NICE's guideline on [patient experience in adult NHS services](#).

1.3.3 Health and social care practitioners, including care home managers and out-of-hours GPs, responsible for transferring people into hospital should ensure that the admitting team is given all available relevant information. This may include:

- advance care plans
- behavioural issues (triggers to certain behaviours)
- care plans
- communication needs
- communication passport
- current medicines
- hospital passport
- housing status
- named carers and next of kin
- other profiles containing important information about the person's needs and wishes
- preferred places of care.

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

1.3.5   The admitting team should provide the person and their family, carer or advocate with an opportunity to discuss their care. Also provide the following information:

- 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 main contact (this is not necessarily the discharge coordinator)
- possible options for getting home when they are discharged from hospital
- care and treatment after discharge.

1.3.6   The admitting team must identify whether there is a need for reasonable adjustments to be made to accommodate the person in hospital. This is in line with the Equalities Act 2010. Examples include:

- providing communication aids (this might include an interpreter)
- ensuring there is enough space around the bed for wheelchair users to move from their bed to their chair
- appropriate adjustments for carers.

Establishing a hospital-based multidisciplinary team

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. The composition of the team should reflect the person's needs and circumstances. Members could include:

- doctor

- nurse
- therapists
- mental health practitioner
- pharmacist
- dietitian
- specialists in the person's conditions
- social worker
- housing specialist
- voluntary sector practitioners.

1.3.8   The hospital-based multidisciplinary team should work with the community-based multidisciplinary team to provide coordinated support for older people, from hospital admission through to their discharge home.

Assessment and care planning

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.

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

1.4   During hospital stay

1.4.1   Record multidisciplinary assessments, prescribed and non-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.

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.

1.4.3   Hospital-based practitioners should keep people regularly updated about any changes to their plans for transfer from hospital.

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

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.)

1.4.6   Encourage people to follow their usual daily routines as much as possible during their hospital stay.

1.5   Discharge from hospital

Discharge coordinator

1.5.1   Make a single health or social care practitioner responsible for coordinating the person's discharge from hospital. Create either designated discharge coordinator posts or make members 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.

1.5.2   Ensure that the discharge coordinator is a central point of contact for health and social care practitioners, the person and their family during discharge planning. The discharge coordinator should be involved in all decisions about discharge planning.

Communication and information sharing

1.5.3   Health and social care organisations should agree clear discharge planning protocols.

1.5.4   Ensure that all health and social care practitioners receive regular
         briefings on the discharge planning protocols.

1.5.5   During discharge planning, the discharge coordinator should share
         assessments and updates on the person's health status, including
         medicines information, with both the hospital- and community-
         based multidisciplinary teams.

1.5.6   The hospital-based doctor responsible for the person's care should
         ensure that the discharge summary is made available to the
         person's GP within 24 hours of their discharge. Also ensure that a
         copy is given to the person on the day they are discharged.

1.5.7   Make a member of the hospital-based multidisciplinary team
         responsible for providing carers with information and support. This
         could include:

         • printed information
         • face-to-face meetings
         • phone calls
         • hands-on training, including practical support and advice.

1.5.8   The discharge coordinator should provide people who need end-of-
         life care, their families and carers with details of who to contact
         about medicine and equipment problems that occur in the 24 hours
         after discharge.

1.5.9   The discharge coordinator should consider providing people with
         complex needs, their families and carers, with details of who to
         contact about medicine and equipment problems that occur in the
         24 hours after discharge.

Discharge planning: key principles

1.5.10   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](#).

1.5.11   Ensure that people do not have to make decisions about long-term residential or nursing care while they are in crisis.

1.5.12   Ensure that any pressure to make beds available does not result in unplanned and uncoordinated hospital discharges.

Discharge planning

1.5.13   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. For example:

- homelessness
- safeguarding issues
- lack of a suitable placement in a care home
- the need for assessments for eligibility for health and social care funding.

1.5.14   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.

1.5.15   The discharge coordinator should ensure that the discharge plan takes account of the person's social and emotional wellbeing, as well as the practicalities of daily living. Include:

- details about the person's condition
- information about the person's medicines
- contact information after discharge
- arrangements for continuing social care support
- arrangements for continuing health support
- details of other useful community and voluntary services.

1.5.16　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).

1.5.17　The discharge coordinator should arrange follow-up care. They should identify practitioners (from primary health, community health, social care, housing and the voluntary sector) and family members who will provide support when the person is discharged and record their details in the discharge plan.

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. Ensure that any essential specialist equipment and support is in place at the point of discharge.

1.5.19　Once assessment for discharge is complete, the discharge coordinator should agree the plan for ongoing treatment and support with the community-based multidisciplinary team.

1.5.20　A relevant health or social care practitioner should discuss with the person how they can manage their condition after their discharge from hospital. Provide support and education, including 'coaching', if needed. Make this available for carers as well as for people using services.

1.5.21　Consider supportive self-management as part of a treatment package for people with depression or other mental health difficulties.

Discharge planning for end-of-life care needs

1.5.22　Ensure that people needing end-of-life care are offered both general and specialist palliative care services, according to their needs.

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.

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

Early supported discharge

1.5.25   Ensure that older people with identified social care needs are
          offered early supported discharge with a home care and
          rehabilitation package.

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

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.

1.5.28   If a person is homeless, the discharge coordinator should liaise
          with the local authority housing options team to ensure that they
          are offered advice and help.

Involving carers

1.5.29   The hospital- and community-based multidisciplinary teams should
          recognise the value of carers and families as an important source
          of knowledge about the person's life and needs.

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

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

- willingness and ability to provide support
- circumstances, needs and aspirations
- relationship with the person
- need for respite.

Support and training for carers

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

1.5.33   Ensure that training is available to help carers provide practical support. 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.

1.5.34   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.

1.5.35   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). Take into account the fact that their needs may change over time.

After transfer from hospital

1.5.36   Community-based health and social care practitioners should maintain contact with the person after they are discharged. Make sure the person knows how to contact them when they need to.

1.5.37   An appropriately skilled practitioner should follow up people with palliative care needs within 24 hours of their transfer from hospital to agree plans for their future care.

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

1.6   Supporting infrastructure

1.6.1   Ensure that a range of local community health, social care and voluntary sector services is available to support people when they are discharged from hospital. This might include:

- reablement (to help people re-learn some of the skills for daily living that they may have lost)
- other intermediate care services
- practical support for carers
- suitable temporary accommodation and support for homeless people.

1.6.2   Have a multi-agency plan to address pressures on services, including bed shortages.

1.6.3   Ensure that all care providers, including GPs and out-of-hours providers, are kept up to date on the availability of local health, social care and voluntary services for supporting people throughout transitions.

1.6.4   Ensure that 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.

1.7   Training and development

1.7.1   Ensure that all relevant staff are trained in the hospital discharge process. Training should take place as early as possible in the course of their employment, with regular updates. It could include:

- interdisciplinary working between the hospital- and community-based multidisciplinary teams, including working with people using services and their carers
- discharge communications

- awareness of the local community health, social care and voluntary sector services available to support people during their move from hospital to the community
- how to get information about the person's social and home situation (including who is available to support the person)
- learning how to assess the person's home environment (home visits)
- how to have sensitive discussions with people about end-of-life care
- medication review in partnership with the person, including medicines optimisation and adherence
- helping people to manage risks effectively so that they can still do things they want to do (risk enablement)
- how to arrange, conduct or contribute to assessments for health and social care eligibility.

2 Research recommendations

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

2.1 Training for hospital and social care practitioners

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 the effects on formal and informal carers, and on avoidable readmissions?

Why this is important

There is a lack of UK evidence. There is some evidence from US studies that training improves medical students' confidence in planning hospital discharge. It also shows that dedicated transitions training involving home visits helps medical and pharmacy students appreciate the person's home environment and how it may affect discharge decisions. It does not show whether this translates into improved outcomes or systems.

Comparative studies on staff training are needed to examine which approaches improve outcomes for people and their carers, including safety and safeguarding. They should also examine whether training improves discharge systems and service level outcomes.

Qualitative data are needed from hospital and community practitioners involved in transitions (including managers and frontline practitioners) about their perceptions and experiences of training. Interviews and qualitative studies are needed with people using services and their carers to gauge their views of the skills and competence of practitioners.

The views of commissioners and provider organisations on their experiences of training are needed. A scoping study could identify the range and content of current training and ongoing support for practitioners involved in transitions. The outputs of this could inform future study design.

Criterion	Explanation
Population	Health and social care practitioners involved in supporting people making transitions between inpatient hospital settings and community or care home settings.
Intervention	Training, supervision and support to health and social care practitioners, including joint or shared learning across sectors and settings.
Comparator(s)	Staff who receive training, supervision and support interventions vs staff who do not; different models for training, supervision and support.
Outcomes	Health-related quality of life. Social care-related quality of life. Health and social care service use including unplanned hospital readmission. Delays in transfer. Inappropriate admissions to residential or nursing care Service user and carer experience:

	- satisfaction - social, emotional and psychological support - choice, control and involvement in decision-making - quality and continuity of care - dignity and independence - quality of life and health status - independence and ability to carry out daily activities - safety and safeguarding outcomes. For results to be valid and reliable, outcomes should ideally be measured using validated tools. Where this is not possible the outcome measure should be detailed in the study. Health-related quality of life should be assessed using an EQ–5D questionnaire so that a cost–utility analysis can be conducted and social care-related quality of life should be measured via the Adult Social Care Outcomes Toolkit in order to allow comparison with other studies.
Study design	Scoping studies may include rapid reviews of training material content, pathway or service mapping, and logic modelling. The aim would be to identify what training is delivered, when and how, and the impact it is expected to make, to inform future in-depth comparative studies (which might be those of randomised controlled trial – RCT – or case control design, for example).

2.2 Self-management support for people with mental health difficulties

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

Why this is important

Current evidence is contradictory and is specific to people with heart conditions. It is not clear whether certain types of transition support is more effective for people with mental health difficulties or more acceptable or preferable from their point of view. Groups with different health or social care needs may need different approaches.

Research is needed on the effect of assessing mental health needs at admission and discharge for different populations. Detailed examination is

needed of the components of effective interventions to discover what works, how and for whom.

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

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

Criterion	Explanation
Population	People who have mental health difficulties and who also have a physical condition and are moving into and out of general inpatient hospital settings.
Interventions	Support for people to self-manage their mental and physical conditions in hospital and community settings (including education, peer support, input by specialist or liaison psychiatry staff, etc.). Assessment of mental health needs (at admission and discharge) to underpin provision of self-management support.
Comparator(s)	'Usual care' refers to that experienced at transitions by people with mental health difficulties moving into and out of general inpatient hospital settings which does not include self-management support.
Outcomes	Health-related quality of life. Social care-related quality of life. Health and social care service use including unplanned hospital readmission and admission to acute mental health services. Delays in transfer. Inappropriate admissions to residential or nursing care. Service user and carer experience: - satisfaction - social, emotional and psychological support - choice, control and involvement in decision-making - quality and continuity of care - dignity and independence - quality of life and health status - independence and ability to carry out daily activities - safety and safeguarding outcomes.
Study design	In-depth comparative studies (which might be those of RCT or case control design, for example) of interventions would be useful. Qualitative studies, or components of comparative studies, concerning the views and experiences of this population, and what they think is

	helpful, are also required.

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

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

Why this is important

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

Cost-effectiveness analyses are needed to determine the cost of assessing this group's needs in hospital and in specialist units, and the cost of health and social care, unpaid care, and the effects on employment and housing.

Determining the cost of assessment while in hospital is particularly important for patients with dementia or delirium because early identification of difficulties might lead to long-term savings for the public sector and society.

Research is needed on what measures are effective in preventing, managing or resolving dementia or delirium during transfer. Research is also needed on what training is most effective for hospital staff supporting people with mental health difficulties during the transition.

Criterion	Explanation
Population	People who have mental health difficulties, including dementia, and who also have a physical condition and are moving out of general inpatient hospital settings. Unpaid or family carers are also within the remit.
Interventions	Support for people with mental and physical conditions who are leaving (general or specialist) hospital settings, whether initiated during the inpatient episode, at discharge or shortly after discharge.
Comparator(s)	'Usual care' refers to that experienced at transitions by people with mental health difficulties moving out of general inpatient hospital settings which does not include specific interventions.

Outcomes	Health-related quality of life.
	Social care-related quality of life.
	Health and social care service use including unplanned hospital readmission and admission to acute mental health services.
	Delays in transfer.
	Admissions to residential or nursing care.
	Need for formal and unpaid care and support.
	Service user and carer experience: - satisfaction - social, emotional and psychological support - choice, control and involvement in decision-making - quality and continuity of care - dignity and independence - quality of life and health status - independence and ability to carry out daily activities - safety and safeguarding outcomes - housing needs.
	Outcomes for informal or family carers (as above) and impact on need for unpaid care, and consequent effects on employment of carers.
	The costs of models of specialist assessment and care, compared with those of general care. Costs of subsequent outcomes (for example, paid and unpaid care, intensity of home care support, loss of employment or income, readmissions) should also be considered.
Study design	Cost-effectiveness studies and RCTs of specific interventions.
Timeframe	Studies should be of sufficient duration to capture outcomes such as mortality, hospital readmissions and transfer to residential services.

2.4   Geriatric assessment and care

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

Why this is important

Currently there is no UK evidence in this area.

International evidence (mainly from the US) and evidence from the economic analysis carried out for this guideline suggest that care in a specialist unit is likely to be cost effective. But in England most older people – including those with complex needs – are treated on general wards.

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

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

Criterion	Explanation
Population	Older people who have been admitted to inpatient settings, whether for physical and or mental health difficulties, including dementia. Older people generally implies over 65 but people vulnerable to early onset of age-related conditions may be considered. Unpaid or family carers are also within the remit.
Interventions	Assessment and care, including discharge planning, within specialist geriatric hospital settings for older people with mental and physical conditions.
Comparator(s)	Assessment and care, including discharge planning, within general (non-geriatric) settings for older people with mental and physical conditions.
Outcomes	Health-related quality of life. Social care-related quality of life. Health and social care service use including unplanned hospital readmission. Delays in transfer. Admissions to residential or nursing care. Need for formal and unpaid care and support. Service user and carer experience: - satisfaction - social, emotional and psychological support - choice, control and involvement in decision-making - quality and continuity of care - dignity and independence - quality of life and health status - independence and ability to carry out daily activities - safety and safeguarding outcomes - housing needs. Outcomes for informal or family carers (as above) and impact on need for unpaid care, and consequent effects on employment of carers. The costs of models of specialist assessment and care, compared with those of general care. Costs of subsequent outcomes (for example, paid and unpaid care, intensity of home care support, loss of employment or income) should also be considered.

Study design	Cost-effectiveness studies and RCTs of specific services and interventions.
Timeframe	Studies should be of sufficient duration to capture outcomes such as mortality, hospital readmissions and transfer to residential services (for example, within 6 or 12 months following discharge).

2.5 Assessment at home to improve hospital discharge success rates

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

Why this is important

Little research has been conducted in this area. There is some evidence that older people find hospitals alienating because of the negative impact on their routine. One Australian qualitative study highlighted the challenge for occupational therapy if it is decontextualised from normal life, but the findings could not be extrapolated to UK practice.

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

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

Criterion	Explanation
Population	People of all ages who have or will shortly be discharged from inpatient settings, following admission to treat physical and or mental health conditions. Unpaid or family carers are also within the remit.
Interventions	Assessment of health and social care needs carried out in the home, either before, during or after discharge, designed to improve discharge

	outcomes.
Comparator(s)	Assessment of health and social care needs carried out in a hospital setting, either before, during or after discharge in a clinic setting.
Outcomes	Health-related quality of life.
	Social care-related quality of life.
	Health and social care service use including unplanned hospital readmission and admission to acute mental health services.
	Delays in transfer.
	Admissions to residential or nursing care.
	Need for formal and unpaid care and support.
	Service user and carer experience:
	- satisfaction
	- social, emotional and psychological support
	- choice, control and involvement in decision-making
	- quality and continuity of care
	- dignity and independence
	- quality of life and health status
	- independence and ability to carry out daily activities
	- safety and safeguarding outcomes
	- housing needs.
	Outcomes for informal or family carers (as above) and impact on need for unpaid care, and consequent effects on employment of carers.
Study design	Cost-effectiveness studies and RCTs of specific services and interventions.
Timeframe	Studies should be of sufficient duration to capture outcomes such as mortality, hospital readmissions and transfer to residential services (for example, within 6 or 12 months following discharge).

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 target group for this guideline was defined as any adult over the age of 18 who 'needs personal care and other practical assistance by reason of age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs, or any other similar circumstances' (as based on the definition of social care in

the Health and Social Care Act 2012, Section 65). Studies did not always explicitly state that the population of the study had social care needs per se but the systematic reviewers endeavoured to discern the population's level of need through the descriptions offered in the study.

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 2 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), and 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
- sample size and method of recruitment

- whether samples are representative of the population we are interested in
- transparency of reporting and limitations that are acknowledged by the research team.

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

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

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

The presentation of evidence in this section

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Due to the interrelatedness of some of the review areas, evidence was found to be overlapping. This was particularly so for the hospital admission process, hospital discharge and reducing readmissions review areas. As the review work progressed through the development phase, the Guideline Committee had an increasing body of evidence on which to develop recommendations. They were able to consider findings from one review area and apply them to the refinement of recommendations in other areas. Where evidence from one review area was used to inform recommendations in another area, this is described in Section 3, including the 'Linking evidence to recommendations' tables (3.8.3).

3.1 Transitions between hospital and home for people with mental health difficulties

Introduction to the review questions

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

Only a small amount of evidence was located and reviewed for this review area. Data on views and experiences were particularly lacking. The 1 included views study examined the experiences of people with dementia during admission to hospital, via interviews with family carers. There were 3 studies reporting effectiveness data, 2 of which were conflicting in their findings about the outcomes of supportive self-management for people with mental health difficulties following treatment for a heart condition. Although the quantity of evidence was lacking in this area, the quality of studies was judged to be moderate to good.

Review question(s) for evidence of effectiveness

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

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

Review question(s) for evidence of views and experiences

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

Summary of review protocol

The protocol sought to identify studies that would:

- identify the effectiveness of the different ways (including specific interventions) in which adults with mental health difficulties and social care needs are supported through safe and timely transfers of care from general inpatient hospital settings to community or care home settings
- identify emerging models of mental healthcare, assessment and discharge planning and associated outcomes
- assess the cost effectiveness of interventions designed to improve transitions between inpatient hospital settings and community or care home settings, specifically for people with mental health difficulties and social care needs.

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

- describe the self-reported views and experiences of adults with social care needs and mental health difficulties, their families and unpaid carers about the care and support they receive during transition into and out of inpatient hospital settings
- highlight aspects of care and support during transitions that work well, as perceived by service users with mental health difficulties, their families and unpaid carers, and aspects of care and support during transitions, which are perceived not to work well
- describe the views and experiences of people delivering, organising and commissioning social care, health and housing services
- highlight aspects of transition into and out of hospital for people with mental health difficulties, which work well, and are personalised and integrated, as

perceived by practitioners, managers and commissioners and aspects of admission and discharge which should be changed to improve transitions

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

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

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

Intervention: Personalised and integrated assessment and admission processes, discharge planning and care and support specifically for people with mental health difficulties.

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

Outcomes: User and carer related outcomes (such as user and carer satisfaction; quality and continuity of care; quality of life (measured using specific mental health quality of life tool); choice and control; involvement in decision-making, suicide rates and mortality) and service outcomes such as use of health and social care services, delayed transfers of care and rates of hospital readmissions within 30 days (see 4.4 in the scope).

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

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

- systematic reviews of studies of different models of discharge assessment, admissions, discharge and care planning for people with mental health difficulties
- RCTs of different approaches to discharge assessment and care planning for people with mental health difficulties
- controlled studies of different approaches to discharge assessment and care planning for people with mental health difficulties
- economic evaluations.

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

- systematic reviews of qualitative studies on this topic
- qualitative studies of user and carer views of social and integrated care
- qualitative components of effectiveness and mixed methods studies
- observational and cross-sectional survey studies of user experience.

Full protocols can be found in Appendix A.

How the literature was searched

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

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

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

Searches were also rerun in June 2015 and a summary of the studies for this review area can be found in Section 3.8.1.

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

How studies were selected

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

- language (must be in English)
- population (must be over 18 years of age and have a social care need)
- transition (a transition into or out of an inpatient hospital setting must have occurred within the last 30 days)
- intervention (must be involved in supporting transitions)
- setting (inpatient hospital setting, intermediate care setting, community setting or care home)

- country (must be UK, European Union, Denmark, Norway, Sweden, Canada, USA, Australia or New Zealand)
- date (not published before 2003)
- type of evidence (must be research)
- relevance to (one or more) review questions.

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

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

In our initial screen (on title and abstract), we found 51 studies which appeared relevant to the review questions on mental health transitions. We ordered full texts and reviewed 35 papers for final inclusion. For views and experiences research, studies from a UK setting were prioritised. Effectiveness studies were restricted to systematic reviews, RCTs or controlled studies. On reviewing the full texts, we identified 4, which fulfilled the criteria (see included studies below), 1 of which reported economic evidence. The included studies (see below) were critically appraised using NICE tools for appraising different study types, and the results tabulated. Further information on critical appraisal is given in the introduction at the beginning of Section 3. Study findings were extracted into findings tables. For full critical appraisal and findings tables, see Appendix B.

Narrative summaries of the included evidence

Studies reporting effectiveness data (n=3)

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

Outline: This is an RCT of moderate quality (+) to measure the impact of a targeted self-care teaching intervention on heart failure knowledge, self-care and 30-day readmission rates for heart failure patients with mild cognitive impairment. The study intervention was administered by a case manager and was based on principles of cognitive training. It focused on environmental manipulations and training compensatory strategies for working with impairments in memory and executive functioning, and on improving patients' self-confidence to manage their health.

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

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

Outline: This is a randomised controlled trial of moderate quality (+). The study was conducted in a large acute general hospital in the UK with the aim of evaluating a best practice model of care for older people with cognitive

impairment. The model, a specialist unit in the hospital, featured joint staffing by medical and mental health professionals, enhanced staff training in delirium, dementia, and person-centred dementia care and the provision of organised purposeful activity. The outcome of primary interest to the researchers was 'number of days spent at home over the 90 days after randomisation'. Participants, aged over 65, were recruited to the study from the mental health unit and from geriatric and general medical wards.

Results: Using the primary outcome measure the study found that this specialist mental health unit had no significant effect on the number of days patients spent at home (51 vs 45 days) or in the hospital (16 vs 16 days in total). Specifically; patients in the mental health unit and patients in the 'standard' wards had the same length of hospital stay (11 days); mortality was lower (but not significantly so) among the intervention patients (22 vs 25%); readmission rates were lower (but not significantly so) for the intervention group; patients returning home from the 'standard' ward spent an average of half a day longer at home than patients from the mental health unit and there were fewer new admissions to care homes (but not significantly so) among patients from the mental health unit (20 vs 28%).

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

3. Rollman Bruce L (2009) The Bypassing the Blues Treatment Protocol: stepped collaborative care for treating post-CABG depression: a randomized control trial

Outline: This is a good quality effectiveness study (++) to measure the impact of telephone-delivered collaborative care on patients who are suffering from post-coronary artery bypass graft (CABG) depression in the US. At the time of publication it was the first treatment trial for depression in cardiac populations to use a treatment package that involves follow-up from a non-physician 'care manager'. The intervention was delivered by a nurse care manager who offered the discharged patient support in multiple ways: educating them about their illness, teaching them self-management techniques and facilitating co-management or transfer of care if necessary.

Results: The randomised group of 150 depressed patients which received the collaborative care intervention, reported greater improvements (all p≤0.02) in mental health related quality of life, physical functioning, and mood symptoms; and were more likely to report a ≥50% decline in their Hamilton Rating Scale for Depression score from baseline than depressed patients randomised to their physicians' usual care (n=152) (p<0.001). Rate of readmissions appeared similar between groups.

Studies reporting views and experiences data (n=1)

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

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

Results: The key findings from the interviews were:

- admission to acute care is a disruption from normal routine; it is a distressing, disorientating time for older patients with cognitive impairment and their carers

- carers have community support services withdrawn after a few days in hospital and have to re-request support upon discharge

- effective communication, which is triadic, rather than dyadic, is essential in order to allow family carers and healthcare professionals to work in partnership with each other and deliver the best quality care for this population – especially when carers are acting as advocates for patients with dementia and/or delirium and supplying knowledge of patients' 'personhood'.

Studies reporting evidence of cost effectiveness (n=1)

One UK RCT (Goldberg et al 2013, n=600 +) compared individual and service level outcomes of a personalised geriatric intervention for older people presenting with undifferentiated confusion and often reaching end of life with standard care at acute geriatric (70%) or general medical wards (30%). This study was not an economic evaluation. However, it applied the EQ-5D which is a standardised measure for health utility (typically used in cost-effectiveness studies in health); and it measured a wide range of relevant service use outcomes. It could thus inform the economic evidence and was included in the economic review. For individual level outcomes, the study did not find significant changes for patients' physical health (via EQ-5D completed by patients; n=251; 0.59 vs. 0.57; p=0.96; via EQ-5D completed by on behalf of patients; n=263; 0.26 vs. 0.31; p=0.06) and overall mortality (n=68 vs. n=71, p=0.89), and carers' psychological wellbeing (via GHQ; n=253; 12.5 vs 12.0; p=0.05). There were also not significant changes in service level outcomes relevant from a hospital and residential care perspective including days spent at home (51 vs 41; p=0.3), care home admission (20 vs 28%; 95% CI for difference -16 to 0%), hospital readmission (32 vs 35%, 95% CI for difference -10 to 5%). Results were not different for specific groups of people such as those admitted with delirium, from care home, those who spent longer than 5 days in hospital, or whether the person using standard care was in geriatric or general ward. This study did not include measures of the impact

on unpaid care and the intensity of community care packages. The study did not find significant changes in individual or service level outcomes and it was thus not indicated that this particular type of intervention was likely to be cost-effective. Additional economic analysis was not considered useful. This intervention was targeted at a very specific group of people and did thus not allow generalisable conclusions to be developed about the likely cost-effectiveness of other interventions to support people with mental health difficulties.

Evidence statements (including economic evidence statement)

MH1	There is a small amount of good quality evidence from 1 qualitative study about the hospital admission process for older people with mental health difficulties. 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 healthcare 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 difficulties 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, 1 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 readmissions appeared similar.
MH3	There is a small amount of evidence of moderate quality from 1 RCT 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 difficulties 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.

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

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

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

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

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

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

Introduction to the review questions

The purpose of these review questions was to examine research about the effectiveness and cost-effectiveness of different ways (including specific interventions) of supporting people with end of life care needs during transition between general inpatient hospital settings and home. This includes admission to hospital and transfer of care from hospital to the community,

including care homes and hospices. The questions also aimed to consider research which systematically collected the views of people using services, their carers and care and support staff in relation to those transitions.

A moderate amount of evidence from studies of views and experiences was located and reviewed for this review area. The studies were mainly of good quality and represented the full spectrum of perspectives including people using services, their carers and practitioners. One of the included views and experiences was from outside the UK, because it was considered to provide valuable data relating to the living-dying interval that that could be applied beyond the study context (the US). In contrast to the views and experiences studies, only 1 controlled study of effectiveness was located and reviewed. This is unsurprising given the focus of the review question. This evidence gap prompted the Guideline Committee to call for an expert witness on the subject of transitions for people with end of life care needs (see Appendix D)

Review question(s) for evidence of effectiveness

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?

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?

Review question(s) for evidence of views and experiences

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

Summary of review protocol

The protocol sought to identify studies that would:

- identify the effectiveness of the different ways (including specific interventions) in which adults with end of life care needs are supported

through safe and timely transfers of care from general inpatient hospital settings to community or care home settings (including hospices)

- identify emerging models of end of life care, assessment and discharge planning and associated outcomes
- assess the cost-effectiveness of interventions designed to improve transitions between inpatient hospital settings and community or care home settings, specifically for people with end of life care needs.

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

- describe the self-reported views and experiences of adults with end of life and social care needs, and those of their families and unpaid carers, about the care and support they receive during transition into and out of inpatient hospital settings
- highlight aspects of care and support during transitions for people with end of life care needs that work well, as perceived by service users, their families and unpaid carers, and aspects of care and support during transitions which are perceived not to work well
- describe the views and experiences of people delivering, organising and commissioning social care, health and housing services.
- highlight aspects of transition into and out of hospital for people with end of life care needs which work well, and are personalised and integrated, as perceived by practitioners, managers and commissioners and aspects of admission and discharge which should be changed to transitions
- contextualise the views of users, carers and practitioners by identifying barriers and facilitators to improved or changed practice they suggest would improve outcomes relating to transitions into and out of inpatient hospital settings for people end of life care needs.

Population: Adults aged 18 years and older, with end of life care needs who are transferring between (general) inpatient hospital settings and community or care home settings, including hospices, and their families, partners and carers. Self-funders and people who organise their own support and who are

experiencing a transfer of care between (general) inpatient hospital settings and community or care home settings are included.

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

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

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

Outcomes: User and carer related outcomes (such as user and carer satisfaction; quality and continuity of care; quality of life – assessed using an appropriate end of life care outcome measure; choice and control in relation to place of death and involvement in planning) and service outcomes such as use of healthcare including palliative care and social care services, delayed transfers of care and rates of hospital readmissions within 30 days (see 4.4 in the scope).

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

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

- systematic reviews of studies of different models of discharge assessment and care planning for people with end of life care needs
- RCTs of different approaches to discharge assessment and care planning for people with end of life care needs
- controlled studies of different approaches to discharge assessment and care planning for people with end of life care needs
- economic evaluations.

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

- systematic reviews of qualitative studies on this topic
- qualitative studies of user and carer views of social and integrated care
- qualitative components of effectiveness and mixed methods studies
- observational and cross-sectional survey studies of user experience.

Full protocols can be found in Appendix A.

How the literature was searched

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

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

The search for material on this topic was carried out within a single broad search strategy used to identify material which addressed all the agreed review questions on the transition between inpatient hospital settings and community or care home settings for adults with social care needs. The searches were restricted to studies published from 2003 in order to incorporate the Community Care (Delayed Discharges) Act 2003. Generic and

specially developed search filters were used to identify particular study designs, such as systematic reviews, RCTs, economic evaluations, cohort studies, mixed method studies and personal narratives. The database searches were not restricted by country.

Searches were also rerun in June 2015 and a summary of the studies for this review area can be found in Section 3.8.2.

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

How studies were selected

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

- language (must be in English)
- population (must be over 18 years of age and have a social care need)
- transition (a transition into or out of an inpatient hospital setting must have occurred within the last 30 days)
- intervention (must be involved in supporting transitions)
- setting (inpatient hospital setting, intermediate care setting, community setting or care home)
- country (must be UK, European Union, Denmark, Norway, Sweden, Canada, USA, Australia or New Zealand)
- date (not published before 2003)
- type of evidence (must be research)
- relevance to (one or more) review questions.

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

Full texts were again reviewed for relevance and research design. If still included, critical appraisal (against NICE tools) and data extraction (against a

coding set developed to reflect the review questions) was carried out. The coding was all conducted within EPPI Reviewer 4, and formed the basis of the analysis and evidence tables. All processes were quality assured by double coding of queries, and of a random sample of 10%.

In our initial screen (on title and abstract), we found 113 studies, which appeared relevant to the review questions on end of life care transitions. We ordered full texts and reviewed 62 papers for final inclusion. For views and experiences research, studies from a UK setting were prioritised. Effectiveness studies were restricted to systematic reviews, RCTs or controlled studies. On reviewing the full texts, we identified 6, which fulfilled the criteria (see included studies below). In addition, there were 2 economic studies (see below in econ para). The included studies (see below) were critically appraised using NICE tools for appraising different study types, and the results tabulated. Further information on critical appraisal is given in the introduction at the beginning of Section 3. Study findings were extracted into findings tables. For full critical appraisal and findings tables, see Appendix B.

Narrative summaries of the included evidence

Studies reporting effectiveness data (n=1)

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

Outline: This quantitative study is of moderate quality (+). Using hospital records for 2 groups of patients, it compared the effect of an inpatient palliative care team. Previous descriptive studies had associated the palliative care team with greater patient satisfaction, and decreased resource use and costs. This study attempts to isolate the effect of the palliative care team by comparing 2 groups on the discharge disposition and the effect of this on reducing rehospitalisation and improved resource utilisation. Groups were matched on key characteristics such as similar diagnosis, risk of mortality and number of previous hospital stays. Outcomes were: discharged home without services; discharged home with services (including Home Healthcare and

Advanced Illness Management Program); discharged to another facility; and discharged to a hospice.

Results:

- Patients who died within 30 days of discharge were more likely to have been seen by the primary care trust (PCT) and discharged to a hospice (46.% compared to patients receiving usual care (32.4%) (p<0.0001).

Controlling for all other variables,

- patients seen by the palliative care team were 3.24 times more likely than those receiving usual care to be discharged to a hospice (p<0.0001),
- patients seen by the palliative care team were 1.52 times more likely than those receiving usual care to be discharged to a skilled nursing facility (SNF) (p<0.001)
- Patients seen by the palliative care team were 1.59 times more likely than those receiving usual care to be discharged to home with homecare (p<0.0001)

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

Studies reporting views and experiences data (n=5)

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

Outline: This is a good quality study (++) that attempts to fill the gap in knowledge about people's own experience of end of life care in a UK context. The study involved in-depth interviews with older people believed by their physician to be in their last year of life and who had experienced transitions between at least 2 care settings in the last 3 months. Interviews were

conducted at a location of the participant's choice by an experienced qualitative researcher who was also a trainee health psychologist. The average duration of the interview was 90 minutes, recorded with permission. Participants could terminate the interview at any time.

Results: Thematic analysis of the views data revealed 4 groups of views, or themes. They were:

- the prioritisation of the institutional processes
- support across settings
- being heard
- dignity.

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

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

The prioritisation of the institutional processes

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

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

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

Support across settings

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

Being heard

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

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

Dignity

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

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

Linked to:

Hanratty, et al (2012) above

Outline: This is a good quality study (++), which explored the experiences of transition from hospital to home for older adults in the last year of life, recently bereaved family carers and practitioners. The data is supplemented with hospital data and opinion surveys. This study incorporates the service user views data from a previous study (Hanratty et al 2012) and synthesises these

with the views of bereaved carers and practitioners. Therefore while this is a separate study in that the data is combined and reveals new themes, the population overlaps with the other study. Readers interested only in the views of service users should refer to the 2012 paper.

Results: Thematic analysis of the synthesised views data for service users, bereaved carers and practitioners revealed 6 themes. They were:

- an imperfect system with beacons of excellence
- perspectives on the carer's role
- GP and out-of-hours care
- communication and expectations about death and dying
- choice and the influence of personal finances
- interprofessional relationships.

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

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

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

An imperfect system with beacons of excellence

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

Perspectives on the carer's role

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

GP and out-of-hours care

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

Communication and expectations about death and dying

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

Choice and the influence of personal finances

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

Interprofessional relationships

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

'… time is of the essence in palliative care and so … trying to encourage someone to see that actually no, next week is not good enough for this particular patient, it may well be good enough for someone else, but not for this person …' (Hospice medical director P47)

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

Outline: This is a highly relevant, good quality study (++) of the perceptions of key stakeholders about how patient transport and local transport service protocols impact upon patients' choices and place of care at the end of life. The context for the research is the low proportion of people who are supported to die in their preferred place. There is a concern that a lack of available health and social care infrastructure limits efforts to increase the numbers of deaths occurring at home. Transport services may be a contributing factor. In response to this, Marie Curie launched the 'Delivering Choice Programme' in 3 areas of the UK: Lincolnshire, Tayside and Leeds. This paper reports qualitative data from a wider, 4-year evaluation conducted in the 3 pilot areas. Data are reported from interviews with 44 patients, 19 carers, 20 bereaved carers and focus groups with specialist nurses. The qualitative methods used in this study were judged appropriate.

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

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

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

4 (a) What do health, social care and housing practitioners think works well, what does not work well and what could improve the transition

from inpatient hospital settings to community or care home settings? (Note that data relate to transitions to and from hospital, to and from the community and to and from hospices.)

Does not work well

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

There is a perceived lack of willingness of GPs and hospital consultants to discuss 'do not attempt resuscitation' (DNAR) orders with patients and sign them and this was observed to have distressing consequences for all concerned, leading to difficulties when transporting patients. Nurse specialists felt GPs and consultants did not understand the implication that without a signed DNAR, ambulance crew will resuscitate patients en route from home to hospice. Being told about a DNAR is not enough.

Could improve the transition

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

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

Makes it difficult

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

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

There were difficulties raised by both the presence and lack of DNAR orders. Without a DNAR order, some ambulance crews reportedly refuse to transfer a patient from home to hospice or hospital. Even if a DNAR order exists, its timing is critical. It has to be signed less than 48 hours before a planned or emergency ambulance is required.

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

What helps

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

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

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

Outline: This is a good quality study (++) of family members' experiences with a dying nursing home resident. In-depth interviews were conducted with 31 caregivers of residents who had died in the last 2 months. The paper includes but is not limited to issues around hospitalisation from the nursing home and transitions into the nursing home. The 'living-dying interval' is defined as the period of time between the knowledge of an approaching death and the death

itself. This period is obviously relative but the authors describe 3 main stages: (a) an acute crisis with peak anxiety; (b) the chronic living-dying phase, which can be certain or uncertain based on diagnosis and co-morbid conditions; and (c) the terminal phase. The living-dying interval was used in this study as a framework for exploring family caregivers' experiences around a loved one's death. Qualitative methods were used and these are judged appropriate. According to the authors, this approach gave voice to participants' experiences.

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

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

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

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

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

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

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

In view of the emotion and uncertainty surrounding the admission process, it was felt social workers could assist by providing important individual and family interventions. Conversations with families about advance care planning, hospitalisation and end-stage decision-making would help them recognise that residents are approaching death. Chronicling the resident's decline may also help clarify awareness.

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

Outline: This is a qualitative study of moderate quality (+). It analyses data from 2 focus groups that the authors ran with district nurses and community specialist care nurses from across 2 PCTs in the UK. Focusing on how problems in service provision can present barriers to patients dying at home, the results show that poor discharge planning and difficulty in securing additional equipment and services together were both contributing factors to hospital admissions for patients in the last few days and hours of life. A qualitative approach, which enabled exploration of participants' experiences and beliefs, was considered appropriate.

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

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

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

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

The nurses stressed the ineffectiveness of the current system for arranging discharge and criticised discharge planners who are supposed to coordinate a patient's discharge home. Similarly, they felt that hospital staff would sometimes make unrealistic promises about extensive community care packages in order to fob off troublesome relatives of patients who were about to be discharged.

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

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

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

District nurses felt that they could address some of the difficulties experienced if they were involved at an earlier stage in the discharge process. Community

nurses felt that if there was a bit more communication between themselves and the ward staff they could overcome a lot of problems.

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

Studies reporting evidence of cost-effectiveness (n=2)

Two UK RCTs examined the cost-effectiveness of multiprofessional palliative care teams for 2 sub-groups of the population covered in the scope.

The first (Higginson et al 2009 ++ n=46) showed that for people with advanced MS a multiprofessional 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 12 weeks, 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 (Higginson et al 2014 n=82) 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 multiprofessional 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, on the 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 6 weeks (£1,422, 95% CI 897–2101 vs £1,408, 95%CI 899–2023) although the authors reported that costs varied greatly between individuals. An international literature review of economic studies carried out in the UK (Smith et al 2014 -) showed that most types of generic palliative care compared with non-palliative care were likely to achieve cost savings. Although the review was assessed as insufficiently applicable in economic appraisal some of the findings were still relevant and could inform recommendations on potential cost savings (see the economic report for full details).

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, 1 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 patient's 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 hospitalisation 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 1 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	Multiprofessional 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 multidisciplinary 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).

Expert witness testimony

The need for expert testimony

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

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

- the effectiveness and cost-effectiveness of different approaches or services for supporting or improving end of life transitions (with a specific focus on social care input)
- collaborative working
- information-sharing
- Support for carers in the context of end of life transitions
- end of life transitions involving care homes
- reducing hospital readmissions (within 30 days).

Testimony

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

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

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

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

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

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

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

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

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

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

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

3.3   Improving the hospital admission process

Introduction to the review questions

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

A good amount of evidence both from studies of views and experiences and studies of effectiveness were located and reviewed for this review area. The included studies of views and experiences were mainly good quality although most were from outside the UK on the basis that UK studies were lacking and the experiences and views described in the non-UK studies were judged to be transferable. The studies of effectiveness were of mainly moderate quality. Notably, all effectiveness studies related to admission processes involving older people, and none focused on younger adults.

Review question for evidence of effectiveness

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?

Review questions for evidence of views and experiences

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

Summary of review protocol

The protocol sought to identify studies that would:

- identify different approaches to care planning and assessment during admission to inpatient hospital settings from community or care home settings and the ways in which they improve outcomes and experiences
- identify emerging models of coordinated assessment and care planning approaches and associated outcomes.

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

- describe the self-reported views and experiences of adults with social care needs, their families and unpaid carers about the care and support they receive during transition to inpatient hospital settings
- highlight aspects of care and support during the admission process that work well, as perceived by service users, their families and unpaid carers, and aspects of care and support during admission to hospital, which are perceived not to work well
- describe the views and experiences of people delivering, organising and commissioning social care, health and housing services
- highlight aspects of the hospital admission process, which work well, and are personalised and integrated, as perceived by practitioners, managers and commissioners and aspects of admission, which should be changed to improve the transition
- contextualise the views of users, carers and practitioners by identifying barriers and facilitators to improved or changed practice they suggest would improve outcomes relating to the hospital admission process.

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

Housing practitioners, social care practitioners (providers, workers, managers, social workers), and health and social care commissioners involved in delivering social care to people during admission to hospital from community

or care home settings, or intermediate care units, personal assistants engaged by people with social care needs and their families. General practice and other community-based healthcare practitioners.

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

Setting: Inpatient hospital settings ('step up'); bed-based intermediate care settings and service users' home, including sheltered housing accommodation; supported housing; temporary accommodation; care (residential and nursing) homes.

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

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

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

- systematic reviews of studies of different approaches to hospital admission, care planning and assessment
- RCTs of different approaches to assessment, care planning and admission processes
- controlled studies of different approaches to assessment, care planning and admission processes
- economic evaluations.

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

- systematic reviews of qualitative studies on this topic
- qualitative studies of user and carer views of social and integrated care
- qualitative components of effectiveness and mixed methods studies
- observational and cross-sectional survey studies of user experience.

Full protocols can be found in Appendix A.

How the literature was searched

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

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

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

Searches were also rerun in June 2015 and a summary of the studies for this review area can be found in section 3.8.3.

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

How studies were selected

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

- language (must be in English)
- population (must be over 18 years of age and have a social care need)
- transition (a transition into or out of an inpatient hospital setting must have occurred within the last 30 days)
- intervention (must be involved in supporting transitions)
- setting (inpatient hospital setting, intermediate care setting, community setting or care home)
- country (must be UK, European Union, Denmark, Norway, Sweden, Canada, USA, Australia or New Zealand)
- date (not published before 2003)
- type of evidence (must be research)
- relevance to (one or more) review questions.

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

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

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

Narrative summaries of the included evidence

Studies reporting effectiveness data (n=6)

1. Eklund, K., Wilhelmson, K., Gustafsson, H., Landahl, S., and Dahlin-Ivanoff, S. (2013) One-year outcome of frailty indicators and activities of daily living following the randomised controlled trial: 'Continuum of care for frail older people'

Outline: This is a moderate quality (+) RCT which measured the effects of the 'Continuum of Care for Frail Older People' intervention on functional ability in terms of activities of daily living (ADL) and a composite measure of frailty. The intervention applied a person-centred approach with shared decision-making throughout the care chain. Participants in the intervention group (n=85) received collaborative care from a nurse with geriatric competence at the emergency department, the hospital wards, and a multiprofessional team for care and rehabilitation of older people in the municipality with a case manager as the hub. Together a continuum of care was created for the older person from the emergency department, through the hospital ward and on to their own homes.

Results

- The 'Continuum of Care for Frail Older People' intervention succeeded in both improving ADL independence among its participants up to 1 year, and in postponing dependence in ADL up to 6 months.
- At both 3- and 12-month follow-ups the intervention group had a higher odds ratio (OR) in improved degree of ADL independence.
- Improved ADL.
- Three months 42% OR 2.37 (95% CI; 1.20 - 4.68).
- Six months 36% OR 1.50 (95% CI; 0.77-2.94).
- Twelve months 39% OR 2.04 (95% CI; 1.03 - 4.06).
- At 6 months the intervention group maintained ADL independence at a higher rate than the control group:
  - maintained ADL
  - 3 months 38% OR 0.79 (95% CI; 0.42 -1.48)
  - 6 months 32% OR 1.30 (9% CI; 0.66 - 2.59)
  - 12 months 24% OR 0.76 (95% CI; 0.37 - 1.53).
- At 6 months, the intervention group were less likely to have a decreased. ADL independence; however this was not maintained at 12 months:
  - decreased ADL
  - 3 months 20% OR 0.51 (95% CI;0.25–1.04)
  - 6 months 31% OR 0.52 (95% CI;0.27–0.98)
  - 12 months 38% OR 0.67 (95% CI;0.36–1.26).
- There did not appear to be any differences between the groups with regards to change in frailty as a result of the intervention.

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

Outline: This was a good quality (++) highly relevant Cochrane systematic review that included 22 RCTs. Participants were adults aged 65 or older who were admitted to hospital care as an emergency, including all unplanned,

unscheduled, or acute presentations. Studies were also stratified into those delivered by mobile geriatric teams in general wards (teams) and those delivered by dedicated geriatric wards. Both settings of geriatric assessment were compared to usual care, which mostly involved admission to a general medical ward setting under the care of a non-specialist. Included studies were from Australia, Canada, Germany, Norway, Sweden and the US.

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

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

Results

Primary outcome findings

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

Secondary outcomes findings

- Comprehensive geriatric assessment decreased the likelihood of patients living in residential care after an emergency admission to hospital, both in the interim and the scheduled follow-ups. A stronger effect was found for comprehensive geriatric assessment delivered in geriatric wards rather than mobile teams at the scheduled follow-up but not at 6 months.
- The findings for the outcome of death or deterioration showed a significant reduction for the comprehensive geriatric assessment groups compared to

usual care, but there was no significant difference between wards and teams.

- There was a benefit of comprehensive geriatric assessment compared to usual care on the measure of cognitive function, but again no significant difference between groups.

- There was no significant difference in mortality between comprehensive geriatric assessment and usual care and no difference between groups.

- There was no significant difference between comprehensive geriatric assessment and usual care on measures of dependence or death and dependence. Data was not available for teams on measures of dependence so these could not be compared.

- There was no significant difference in ADL or readmission to hospital between comprehensive geriatric assessment and usual care and no difference between groups. No comparisons were made on length of stay given the high heterogeneity of the studies.

- Within ward and team based subgroups, there was no significant in-group difference.

- For use of resources, please see the cost-effectiveness results below.

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

Outline: This is a good quality (++) systematic review of moderate relevance to this review area. It compares the effectiveness of acute geriatric unit care, based on all or part of the Acute Care for Elders (ACE) model and introduced in the acute phase of illness, with that of usual care. Dedicated geriatric units provide prepared environments for older patients admitted into hospital and are based on rehabilitation and function-focused model of care designed specifically to prevent functional decline and related complications. Included papers were from Sweden, the US, Spain, Australia, France and Peru. This paper has already been presented at GC 6 in response to the 'hospital discharge' question; however, the reviewers felt that it was also relevant to the 'admission process' review area.

Results

Individuals receiving acute geriatric unit care experienced:

- fewer falls (risk ratio) RR = 0.51, 95% confidence interval (CI) = 0.29–0.88)

- less delirium (RR= 0.73, 95% CI = 0.61–0.88)

- less functional decline between their baseline 2-week pre-hospital admission status and discharge (RR = 0.87, 95% CI = 0.78–0.97; p= 0.01) than those receiving usual care

- shorter length of hospital stay (weighted mean difference [WMD] = -0.61, 95% CI = -1.16 to -0.05, with outliers removed; significant difference with outliers included)

- fewer discharges to a nursing home (RR = 0.82, 95% CI = 0.68–0.99, with outliers removed; no significant difference with outliers included)

- lower costs (WMD = -$245.80, 95% CI = -$446.23 to -$45.38, with outliers removed; significant difference with outliers included)

- more discharges to home (RR = 1.05, 95% CI = 1.01–1.10)

- fewer pressure ulcers (RR = 0.49, 95% CI = 0.23 to 1.04). A non-significant trend toward fewer pressure ulcers was observed.

- no differences were found in functional decline between baseline hospital admission status and discharge, mortality, or hospital readmissions.

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

Outline: This is a moderate quality (+) systematic review. It aimed to evaluate interventions designed to improve communication of medication lists and advance directives for people over 65 transferring between nursing homes and hospitals. Five studies met the inclusion criteria and of these, 3 were about admission to hospital from a nursing home and 2 were about the transfer of care from hospital to a nursing home. Therefore only 3 of the studies fell within the scope of this review area. All 3 were from the US. Two of them studied the use of a patient transfer sheet on admission to hospital and the other reviewed the use of a prospective order form for life sustaining

treatment. The heterogeneity of the studies precluded meta-analysis of the results of the review.

Results: Use of a 1-page transfer document, developed by community members, nursing home staff, nurses and physicians, with the aim of improving the transition from nursing home to a university hospital emergency department (Madden et al 1998) is attributed to the following findings:

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

Use of a physician order form for life sustaining treatment for end of life care residents in 8 nursing homes is attributed to the following findings. The study population, which was followed for 12 months, had indications of DNR on their forms and 'to transfer only if comfort measures fail' (Tolle et al 1998):

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

Use of a 1-page transfer form for nursing home patients transferring to an emergency department is attributed to the following findings. Information on the form included name and demographic information, the patient's usual mental and physical status, reason for transfer and the patient's DNR status. The presence of pieces of medical information in patients' charts was assessed for 3 months pre- and post-intervention. Successful documentation was defined as 'at least 9 of 11 pieces of medical information' (Terrell 2005): successful documentation increased from 58.5% to 77.8% with use of the transfer form, and the rate of documentation of DNR status rose from 64.6% to 87.5%.

Overall, the review identified no intervention that clearly improved the communication of accurate and appropriate medication lists between nursing homes and hospitals. The review found that 2 unique transfer documents facilitated the transfer of advance directive information from long-term care to emergency departments (Terrell 2005 and Madden 1998), although these studies did not report the accuracy of information transfer.

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

Outline: This is a moderate quality (+) systematic review of RCTs pertaining to navigator models, which support chronically ill older adults undergoing healthcare transitions. Fifteen articles describing 9 discreet studies on navigator models relevant to chronic disease management for older adults in transition were included in the review; the potential impact of each model was examined and the findings were synthesised to identify common elements. Included studies were from the US, Canada and Australia. The mode of inquiry was exploratory. The authors reiterate that the navigator role is still in its infancy and look for elements common to successful interventions.

Results

- The studies demonstrated mixed support for the effectiveness of navigation roles for older adults with at least 1 chronic illness. Although 2 studies

showed little to no positive effect (Gagnon et al 1999; Mayo et al 2008), the corresponding study interventions as described were more passive than the other models reviewed; both initiated care at either discharge or after, rather than on admission.

- Some evaluation studies have revealed an 'investment effect' (Toseland et al 1997) where benefits of the intervention are not seen in the short-term, but are evident in longer term follow-up.

- Of the 9 navigator programmes identified, 5 reported positive economic outcomes, 2 reported higher satisfaction with care for providers and patients and 5 reported increased patient quality of life or functionality.

- Recommended elements for navigator programmes serving chronically ill, multi-morbid, older adults were found to be:

  - qualifications for practitioners: post-secondary healthcare training (registered nurses or masters degree in social work depending on population); advanced gerontological training

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

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

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

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

Results

- Patients from residential aged care allocated to the intervention had dramatically reduced in-hospital mortality (4.1 versus 22.1%, p<0.001), and – importantly – this difference was sustained at 6 months (28.2 versus 44.2%, p=0.02).
- Six-month readmissions (32.7 versus 22.4%, p=0.15) and bed day use (14.7 versus 12.3 days, p=0.24) were non-significantly increased.
- The findings suggest that in-hospital mortality in hospitalised residential aged care patients is poor partly because the usual model of medical ward care does not meet their complex needs. Interdisciplinary care resulted in similar in-hospital mortality rates for RACF residents as for community-dwelling older people.

Studies reporting views and experiences data (n=6)

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

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

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

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

Respondents described hospital as an alien environment. They recalled their lives pre-admission as being full of meaning. This contrasted with life in hospital, which lacked meaning and purpose and mainly comprised of waiting for medical professionals and test results, 'When you're home … you're able to do more. I go walking in a lovely environment, which [I] get a lot of enjoyment from. Whereas walking here, you're just walking to get the exercise and build up your fitness' (p123). People felt alienated by the impact of the hospital on the individual's sense of routine. This was experienced either as a lack of routine, a feeling of a forced routine or a routine dependent on the availability of the staff. The authors conclude that these experiences amount to a form of 'occupational deprivation', seen in the amount of non-occupation – 'waiting'. They believe that the lack of meaning in occupations in hospital has profound implications for occupational therapy, 'With occupational performance de-contextualised from normal life, it is difficult to see how the assessment of performance in the (further decontextualised) environment of functional assessment might be regarded as a direct surrogate for actual performance' (p126).

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

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

Works well

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

Does not work well

Patients realised that relationships and cooperation with staff were fundamental to re-engage with occupations and working with nursing staff helped motivate patients. However, staff routines and workload often meant they were unavailable to help patients and this was frustrating: 'I'm out and about a lot, and I have my independence. And that's the big thing; here you're not independent. It's … sometimes you have to fight for it, sometimes it's just the circumstances don't allow it' (p125).

Could improve admission

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

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

Outline: This high quality (++) qualitative study consisted of 3 iterative, interrelated phases: interviews, creating a photographic narrative journal (PNJ) and photo elicitation focus groups. The aim of the study was to draw on the views of 10 older adult/family caregiver dyads and 14 healthcare professionals (10 emergency department registered nurses and 4 nurse practitioners) to identify factors that facilitate or impede safe transitional care for community dwelling older adults with dementia. The study design was rigorous; however, the efforts to hear the voices of the individuals with dementia were hampered by the effect of the disease on the older adults' stamina and their ability to participate in interview and focus groups. For example, after initially agreeing to participate in the focus group, 4 older adults elected not to take part, resulting in a caregiver-only focus group.

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

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

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

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

Does not work well

For the caregivers, waiting in the emergency department presented two confounding safety issues. First there was concern about the physical problem that required the emergency department visit. Second there was

worry about worsening of the dementia related symptoms by waiting in an environment that they were powerless to modify.

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

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

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

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

Does not work well

Registered nurses and Nurse Practitioners recognised that waiting for long periods could add risk of hunger, dehydration and incontinence, setting up a cascade of decline including hypoglycaemia for diabetic patients.

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

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

Makes it difficult

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

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

Outline: This paper presents the qualitative findings from a good quality (++) mixed methods study. The main study was an evaluation of case management of individuals with long-term conditions (LTCs) by a community matron (CM) service. The qualitative study had a number of aims but the one reported on in this paper was: to assess and evaluate the extent to which a CM service had implemented case management. The qualitative methods involved interviews with CMs (n=15), patients (n=13), family carers (n=8) and secondary care staff who interface with the CMs. Data were also collected via focus groups and audio diaries. The methods were judged to be appropriate but only a small proportion of findings are relevant to the admissions review question.

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

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

Works well

For patients and family carers, knowing that they had a CM and knowing how and when to contact them was important (generally, for example not specifically in relation to admission).

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

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

Works well

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

Could improve admission

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

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

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

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

Works well

CMs reported that even when a person is admitted to hospital, case management continues: 'coordination without interfering'.

One CM reported a success story where she had taught a patient about 'rescue packs' and his hospital admissions subsequently reduced.

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

Does not work well

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

Could improve admission

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

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

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

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

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

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

Managers reported that the way families are involved in decisions about transferring to hospital is partly determined by the urgency of the situation. In

acute emergencies where the priority is immediate treatment, the decision will be made by the staff and the family will be informed as soon as practicable. In non-emergencies, the extent to which the family intervene in the decision is affected by how often they visit and their faith in the nursing home. They often feel guilty about the person being in the nursing home and if there is any doubt will want them to go to hospital so that they know they've done all they possibly could.

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

Works well

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

What works

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

Could improve

Communication between nursing homes and hospitals varies and a number of innovative approaches were reported which aimed to try and improve the situation – for example collaborative and shared care (a visit by emergency department staff to the nursing home so they would understand constraints and conditions in the home), educational and professional support of nursing home staff and alternatives to emergency department and inpatient care.

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

What helps

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

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

Managers reported that residents' admission to hospital has been prevented because the area health service provides a range of community services in the nursing home itself. The services that go into nursing homes most frequently are community aged care assessment, psychogeriatrics, palliative care, wound care, continence care and community nurses. Unfortunately, not all nursing homes are aware that the area health service can provide these services.

Makes it difficult

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

There was fear of criticism and litigation, with nursing home managers concerned that not transferring someone is potentially litigious and may result

in formal complaints. Even if complaints are not upheld, the investigations are time consuming and stressful.

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

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

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

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

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

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

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

Works well

Nine of the 18 participants said that they were fully satisfied with the kind of and amount of care that they had received prior to admission and the rest felt

their care had been adequate: 'There's not much you can do, other than that what they're doing, you know. And that way you can't expect any difference. And well I don't expect miracles anyway' (p225).

Although older people do not perceive the community alarm as having been able to prevent their emergency admissions, it was appreciated for raising their confidence about being at home prior to the admission.

Could improve admission

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

They prefer a service that supports and boosts their capacities, capabilities and social networks and a service that makes them feel safe while remaining inconspicuous when not needed, and that ensures easily accessible help in emergency situations (like the community alarm for example).

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

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

Outline: This qualitative study was judged to be of good quality (++). Its purpose was to describe patient and family caregiver perceptions of transitions between long term services and supports (LTSS) settings and hospitals. LTSS settings include assisted living facilities and nursing homes. The authors sought to understand (a) patient and family involvement in components of transitional care and (b) issues related to the experiences with care provided by professional staff. A total of 57 interviews took place including with 30 nursing home residents, 11 residents of an assisted living facility (ALF), 10 PACE participants (Programme of All-Inclusive Care of the Elderly) and 6 family caregivers of cognitively impaired ALF and nursing home

residents. The methods were judged to be appropriate and reliable and the study is highly relevant to the admission process review question.

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

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

Respondents reported that during admission to hospital, they had limited involvement in planning with professional hospital staff. Nearly 30% of LTSS recipients reported having no conversation with a hospital physician regarding acute medical conditions or planned treatments: 'they didn't have the time' and 'I would have liked the doctor to tell me about my condition, he never came in to tests ... he never told me what my diagnosis was'. Only 33% (19 of 57) of LTSS recipients or family caregivers reported having discussions about their medical condition, with hospital nurses ignoring them and no one giving them any information.

Only 21% of LTSS recipients reported discussions with hospital social workers. One person described how they were told they would be discharged from hospital but having had no information, they objected, 'I ain't leaving here until somebody talks to me' (p44).

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

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

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

Works well

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

Could improve admission

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

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

Studies reporting evidence of cost effectiveness (n=1)

Findings from 1 Cochrane systematic review and meta-analysis (Ellis et al 2011, 19 trials, none from UK, ++) suggested that comprehensive geriatric assessment (CGA) provided on specialist units or through specialist teams led to reduced deterioration (OR=0.76, p=0.001, n=2,622) and improved cognitive function (standard mean difference 0.08, p=0.02, n=3,317) compared with standard non-specialist care. Whilst CGA in specialist units improved service use outcomes such the probability of living at home between 6 weeks and 12 months (OR=1.22, p<0.001, n=6,290) and admission to residential care (OR=0.73, p<0.001; n=6,252), these outcomes were less positive for CGA by specialist teams (OR=0.75, p=0.06, n=772; OR=1.16, p=0.39; n=485). Approaches for evaluating costs varied widely so that the authors did not attempt to synthesise cost results. They found that some (but not all) studies

showed cost savings from the perspective of the hospital and care home system; the wider cost impact (community care, unpaid care) was unclear.

In threshold analysis (details in Appendix C) we showed the likely cost-effectiveness of CGA and care in a UK context. We translated effects on residential care admission and length of hospital stay into a UK context and explored the impact of different values for costs of community based health and social care on total health and social care savings. We also explored the impact of including unpaid care costs in findings. We found that if the annual cost of community health and social care was lower than between £30,000 and £35,000 the intervention was expected to be saving costs from a health and social care perspective. This was about 2.5-fold the costs that have been found in England for older people eligible for publicly funded social care. If the costs of unpaid care were included then annual cost of health and social care needed to be lower than £12,000 to £16,000 in order for the intervention to be cost saving. This was about 1- to 1.3-fold the costs expected for older people eligible for publicly funded social care and thus likely to at least offset costs.

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 2 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 decontextualised from normal life. The study also showed that the best motivator for people to engage in rehabilitation was the prospect of returning home.
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 1 year, and postponed dependence in ADL up to 6 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.
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 2 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.
HA6	There is a small amount of moderate evidence that the involvement of a multidisciplinary 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. An RCT (Eklund et al 2013 +) measured the effects of a multiprofessional 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 1 year, and postponed dependence in ADL up to 6 months.
HA7	No evidence was found from studies published since 2003 about the provision of step-up facilities during the hospital admission process.
EC1	Evidence from 1 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.

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

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

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

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

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

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

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

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

Parke B, Hunter K, Strain L et al (2013) Facilitators and barriers to safe emergency department transitions for community dwelling older people with dementia and their caregivers: A social ecological study. International Journal of Nursing Studies 50: 1206–18

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

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

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

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

3.4   Improving transfer of care from hospital

Introduction to the review questions

The purpose of these review questions was to examine the effectiveness and cost-effectiveness of different approaches to supporting adults with social care needs during transition from inpatient hospital settings to community or care

home settings. The questions also aimed to consider research which systematically collected the views of people using services, their carers, and care and support staff in relation to the transfer of care from hospital.

Overall, a good amount of evidence was located and included for review in this area. There were 12 studies reporting views and experiences and they were mainly of moderate quality. The 16 studies of effectiveness were of mixed (moderate and good) quality, although one low quality study was included. Some of the effectiveness studies also provided cost effectiveness data. A total of 21 papers reporting economic evidence were included for review. It is notable that data on views and data on effectiveness and cost-effectiveness were sometimes conflicting, which suggests that although an intervention or approach to hospital discharge may be effective or cost-effective, it may not be acceptable to the person experiencing transfer from hospital.

Review question for evidence of effectiveness

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

Review questions for evidence of views and experiences

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

Summary of review protocol

The protocol sought to identify studies that would:

- identify the effectiveness of the different ways (including specific services or interventions) in which adults with social care needs are supported through safe and timely transfers of care from inpatient hospital settings to community or care home settings
- identify emerging models of care, assessment and discharge planning and associated outcomes
- assess the cost-effectiveness of interventions designed to facilitate hospital discharge.

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

- describe the self-reported views and experiences of adults with social care needs, their families and unpaid carers about the care and support they receive during transition from hospital to community or care home settings
- highlight aspects of care and support during the hospital discharge process that work well, as perceived by service users, their families and unpaid carers, and aspects of care and support during discharge from hospital which are perceived not to work well
- describe the views and experiences of people delivering, organising and commissioning social care, health and housing services
- highlight aspects of the hospital discharge process which work well, and are personalised and integrated, as perceived by practitioners, managers and commissioners, and aspects of hospital discharge which should be changed to improve the transition
- contextualise the views of users, carers and practitioners by identifying barriers and facilitators to improved or changed practice they suggest would improve outcomes relating to the hospital discharge process.

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

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

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

Setting: Inpatient hospital settings ('step down') bed-based intermediate care settings and service user's home, including sheltered housing accommodation; supported housing; temporary accommodation; care (residential and nursing) homes.

Outcomes: User and carer-related outcomes (such as user and carer satisfaction; quality and continuity of care; choice and control; involvement in decision-making about place of death, and health- and social care-related quality of life) and service outcomes such as use of health and social care services, delayed transfers of care and rates of hospital readmissions within 30 days (see 4.4 in the scope).

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

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

- systematic reviews of studies of different models of discharge assessment and care planning
- RCTs of different approaches to discharge assessment and care planning
- controlled studies of different approaches to discharge assessment and care planning
- economic evaluations.

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

- systematic reviews of qualitative studies on this topic
- qualitative studies of user and carer views of social and integrated care
- qualitative components of effectiveness and mixed methods studies

- observational and cross-sectional survey studies of user experience.

Full protocols can be found in Appendix A.

How the literature was searched

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

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

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

Searches were also rerun in June 2015 and a summary of the studies for this review area can be found in Section 3.8.4.

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

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs – and screened against an exclusion tool informed by the parameters of the

scope. Formal exclusion criteria were developed and applied to each item in the search output, as follows:

- language (must be in English)
- population (must be over 18 years of age and have a social care need)
- transition (a transition into or out of an inpatient hospital setting must have occurred within the last 30 days)
- intervention (must be involved in supporting transitions)
- setting (inpatient hospital setting, intermediate care setting, community setting or care home)
- country (must be UK, European Union, Denmark, Norway, Sweden, Canada, USA, Australia or New Zealand)
- date (not published before 2003)
- type of evidence (must be research)
- relevance to (1 or more) review questions.

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

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

In our initial screen (on title and abstract), we found 583 studies, which appeared relevant to the review questions on improving hospital discharge and reducing readmissions. We ordered full texts and reviewed 183 papers for final inclusion. For views and experiences research, studies from a UK setting were prioritised. Effectiveness studies were restricted to systematic reviews, RCTs or controlled studies. On reviewing the full texts, we identified 28, which fulfilled the criteria (see included studies below) and related to improving discharge. The papers identified as relating specifically to reducing

readmissions were coded accordingly and included in a separate review area, described in the next sub-section.

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

Narrative summaries of the included evidence

Studies reporting effectiveness data (n=16)

1. Bahr, S.J., Solverson, S., Schlidt, A., Hack, D., Smith, J.L. and Ryan, P. (2004) Integrated literature review of post discharge telephone calls

Outline: This systematic review was judged to be of moderate quality (+) and highly relevant to the 'hospital discharge' review area. The systematic review aimed to assess the impact of a post-discharge telephone call on patient outcomes. Building on equivocal evidence from previous research, it set out to answer the question: 'Are post-discharge phone calls made by hospital staff an effective way of improving patient outcomes and easing transition from hospital to home?'

The post-discharge telephone call was defined as a telephone call to the person who was discharged to determine 'how they were doing'. Calls generally took place 1 to 2 weeks after discharge and may be intended to answer patients' questions, review medications, assess coping and check on the status of equipment and supplies. The reviewers examined who placed the call (nurse, pharmacist, phone service personnel). Patients were at least 18 years old and had experienced more than 25 hours in hospital. Included studies were restricted to those with an experimental design and published before 2013. Nineteen studies met the inclusion criteria. The reviewers identified problems with the quality of this review, which is reflected in its moderate rating.

Results

Individual outcomes

Acceptability of post-discharge telephone calls

In the 6 studies that measured patient satisfaction, 2 found that patients who received calls were more satisfied than those who did not and 4 studies found no difference. Two studies found that although people 'liked' the telephone calls, there was no difference in satisfaction.

Medicines

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

Follow-up

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

Self-care management

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

Quality of life

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

Healthcare provider outcomes

Client feedback

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

Service outcomes

Feasibility of post-discharge telephone calls

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

Hospital readmission

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

Emergency department visits

Emergency department visits were evaluated in 4 studies. Mixed results were reported with some showing increased visits, some showing fewer visits and others showing no difference between persons who received post discharge telephone calls and those who did not.

Unscheduled (health) service use

Two studies reported an increased use and 2 reported a decrease in unscheduled service use between groups.

Costs

None of the included studies reported a full economic evaluation of the telephone service. Two reported the cost of the phone calls and 1 study reported that the costs of the calls exceeded the benefits.

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

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

Outline: This is a good quality (++) pragmatic RCT conducted in the UK. It aimed to test the hypothesis that expanding the stroke nurse role to provide continuity in care to stroke survivors and carers after discharge from hospital would improve recovery from stroke. The stroke nurse was to follow up from the place of discharge within 2 working days and review the following:

- physical functioning using activities of living
- patient and carer knowledge of the consequences and implications of stroke
- patient and carer abilities to cope emotionally with the aftermath of stroke
- the potential of the home environment to support recovery
- medication adherence, appropriateness and effectiveness
- transfer of care arrangements
- health promotion, including patient and carer education, stroke prevention and the use of resources to support recovery control group received usual care.

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

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

Results: The authors employed a Mann-Whitney U test for significance testing between 2 mean scores of experimental and control (usual care) conditions, which is appropriate for non-normal distributions:

- between 3–12 months' follow-up, for which there was complete data, there was a significant difference in mean scores in favour of the experimental group on the Barthel Index
- there was no significant difference found between the 2 groups on the Beck Depression Inventory.
- while the Frenchay Activity Index failed to show improvement in the performance of activities with social meaning, the Nottingham Health

Profile subsection showed statistically significant reductions in social isolation

- carers of survivors in the experimental group reported less strain at the 3-month assessment period. The data demonstrate, however, that this effectiveness may be short-term, and therefore dependent on continued receipt of the study intervention.

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

Outline: This is a moderate quality (+) systematic review. It evaluated studies performing medication reconciliation interventions in patients transferred to and from long-term care settings. Of the 7 studies that met the inclusion criteria, only 1 study (Delate 2008) was not about hospital to community or care home transition. The remaining 6 are all about transition to or from hospital. The studies are from the US, Sweden, Belgium and Australia. The results were not pooled or synthesised because of the heterogeneity of the outcomes considered in each study, which is possibly a consequence of not stating the outcomes a priori.

Results

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

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

Outline: This is a good quality systematic review (++). It included a small number of studies that aimed to examine the evidence for services for older patients who developed a crisis, attended hospital, were assessed, treated and discharged, within 72 hours from an acute medical unit or emergency department. Outcomes measured were hospital admissions within 30 days, emergency department use over 30 days, hospitalisation, mortality, nursing home transfers and falls over a year. Interventions in the included studies varied by setting, outcomes timing, and professionals delivering the intervention.

Results

Mortality

- There was no significant difference in mortality at final follow-up when combining data for the 5 trials: n=2,474, risk ratio 0.92 (95% CI 0.55 to 1.52).

Readmissions

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

Functional outcomes

- Only 1 trial reported function (Close). The standardised mean difference on the 20-point Barthel score was 0.41 (95% CI 0.21 to 0.61) in favour of the intervention.
- Quality of life.
- At 4 months there was a mean difference of 0.2 (95% CI -1.9 to 2.3) in the physical component of the SF36, and 0.6 (95% CI -1.3 to 2.5) difference in the mental component of the SF36 – both in favour of the intervention,

although these differences are not clinically meaningful (only reported in Mion).

Intervention type

- Given the range of different interventions that came under the name of 'geriatric assessment' and the different outcomes measured by the included studies, heterogeneity was high. However, an analysis by intervention type revealed that the predominantly nurse-led interventions (n=1,764) gave a risk ratio for readmission of 1.01 (95% CI 0.89 to 1.15), whereas the predominantly geriatrician-led intervention trials (n=710) gave a risk ratio for readmission of 0.81 (95% CI 0.59 to 1,12).

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

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

Outline: This is a good quality (++) systematic review, with moderate relevance to our review area. It pools results from studies that evaluate the effectiveness of one or more components of the ACE model (one component of which is discharge planning) and the effect on hospital acquired functional decline. Included studies were from Sweden, the US, UK, Spain, Australia, France and Peru. It is important to note that although one component of the ACE model is discharge planning, it is not possible to isolate from the results what effect discharge planning alone had on the outcomes selected by this review.

Results

Iatrogenic complications (falls, pressure ulcers, delirium).

- ACE was associated with significantly fewer falls (RR 0.51 p=0.02).

- ACE was associated with significantly less occurrence of delirium (RR=0.73 p<.001).
- Functional decline.
- Meta-analysis of 6 studies indicated individuals receiving ACE were 13% less likely to experience functional decline compared to usual care (RR=0.87 p=0.01).

Length of stay in hospital

- Eleven complete studies Individuals receiving ACE care experienced significantly shorter length of stay than usual care (WMD=-1.28 p=0.02).

Hospital readmissions

- Meta-analysis of 5 studies identified no significant difference within 1 or 3 months of discharge.(RR=1.05, p=.49)

Discharge destination

- Meta-analysis of 9 studies 1.05 times more likely to be discharged home (RR=1.05, p=0.01).

Mortality

- No significant effect in 11 studies.

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

Outline: This was a good quality (++) systematic review and meta-analysis that compared the effectiveness of early discharge planning to usual care. The focus was on the effectiveness of interventions in reducing index length of hospital stay, hospital readmissions and readmission length of stay, and secondarily in reducing mortality and increasing satisfaction with discharge planning and quality of life for older adults admitted to hospital with an acute illness or injury. This review included 7 studies in the final meta-analysis that

ranged in date from 1987–2011. Studies were from the UK, France and Australia.

Results: The review found no significant difference in the effect of early discharge planning on the index length of hospital stay (days) or on mortality. However, it found that older adults who received early discharge planning experienced significantly fewer hospital readmissions within 1 or 12 months of index hospital discharge, and significantly fewer days in hospital after readmission of almost 2 and a half days when compared to usual care.

The early discharge planning group reported higher quality of life scores at 2 weeks and 3 months than the usual care group. No differences were found on other domains, including physical functioning, role limitations due to physical problems, bodily pain, mental health, role limitations due to emotional problems, social functioning and vitality.

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

Outline: This is a good quality systematic review of randomised or controlled trials (++) of interventions designed to improve the transfer of patient care from hospital to primary care on discharge.

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

Results: Effective interventions included:

- medication reconciliation
- electronic tools to facilitate quick, clear, and structured summary generation
- discharge planning

- web-based access to discharge information for GPs

- use of electronic discharge notifications

- shared involvement in follow-up by hospital and community care providers.

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

8. Larsen, T., Olsen, T.S. and Sorensen, J. (2006) Early home-supported discharge of stroke patients: health technology assessment

Outline: This is a moderate quality systematic review (+), which is also of moderate relevance to our review area. It aimed to provide a comprehensive and systematic assessment (HTA) of early home supported discharge by a multidisciplinary team that plans, coordinates and delivers care at home (EHSD). Seven RCTs on EHSD with 1,108 patients followed 3–12 months after discharge are selected for statistical meta-analysis of outcomes. Results from this review are compared with that of conventional rehabilitation stroke units.

Results

- Incidents of poor outcomes (health or institution) reduced by 21.7% in the conventional stroke unit to 14.5% in the EHSD group.

- Referrals to a nursing home or institution reduced by 5% from 11.3% to 6.3%.

- In 6 of the 7 studies, the average length of stay at the hospital is significantly reduced: the pooled effect sizes have a significantly shortened length of initial stay by 10 days (CI, 2.6–18 days) to an average of 22 days, including both the acute phase and the subsequent stroke unit rehabilitation.

- No significant results are observed on the frequency of readmissions.

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

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

Results

- Strong evidence of effectiveness seems to be principally limited to specific diagnostic groups managed in specific settings.
- Developing a single, one-size-fits-all approach within transitional care of the elderly does not appear possible because of the diversity and complexity of elderly healthcare. Targeted interventions are more suitable.
- Successful interventions were found to:
  - commence at an early stage and are maintained throughout hospitalisation and the post-discharge period
  - consist of a key healthcare worker which acts as a discharge coordinator
  - include patient participation and /or education
  - involve family caregivers
  - undertake a multidisciplinary, multi-interventional component approach
  - contain curriculum teaching transitional care
  - contain pharmacy interventions- medication reconciliation
  - ensure standardised medication reports.

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

Outline: This is a good quality (++) RCT which tested the efficacy of an intervention programme, CARE: Creating Avenues for Relative Empowerment, for improving outcomes of hospitalised older adults and their family caregivers. A total of 407 family caregiver-patient dyads were randomised into 2 groups. The intervention group received a 2-session empowerment-educational programme, 1 to 2 days after admission and 1 to 3 days before discharge. Those on the CARE programme were assisted to develop a care plan and received audio-taped and written materials which focused on teaching family caregivers to be more effective and confident in their role. Those in the comparison group received a generic information program that mirrored the timeframe of the intervention.

Results

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

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

Outline: This is a single, blind, randomised control pilot study of moderate quality (+), which tests the feasibility of a discharge management intervention for a larger, well-powered trial. The intervention was administered by nurse care managers, who formulated a discharge plan for patients at high risk of

adverse events. Acutely ill patients fulfilled criteria such as polypharmacy, therapy with anticoagulants or insulin, plus secondary criteria indicating vulnerability. Nurse care managers collaborated with a physician team to initiate and coordinate post-hospital care, both during the hospital stay and for the first 5 days following discharge.

Results

- The intervention group did not differ significantly from the control group when measured at days 1 to 5 after discharge on: deaths, rehospitalisation, urgent consultation or adverse medicine reaction.
- A secondary analysis of individual endpoints showed more rehospitalisations in the intervention group, a difference which reached significance in the time period between days 6 and 30 post-discharge (p=0.026). However, this negative effect can, in part, be explained by 3 patients in the intervention group receiving planned chemotherapy (as opposed to none in the comparison group).
- Despite the small sample size (n=60 acutely ill adults), subjective measures of patient and family caregiver satisfaction with discharge were significantly higher for those receiving the discharge intervention compared to the best usual care.

12. Newcomer (2006) Outcomes in a nursing home transition case-management program targeting new admissions

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

Results

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

13. Olson, D., Bettger, J., Alexander, K., Kendrick, Amy., Irvine, J., Wing, L., Coeytaux, R., Dolor, R., Duncan, P. and Graffagnino, C (2011) Transition of care for acute stroke and myocardial infarction patients: from hospitalization to rehabilitation, recovery, and secondary prevention

Outline: This is a good quality (++) systematic review. It investigated whether evidence supports a beneficial role for coordinated transition of care services for the post-acute care of patients hospitalised with first or recurrent stroke or myocardial infarction (MI). Studies were included if they were published in English from 2000 to 2011 and if they specified post-acute hospitalisation transition of care services as well as prevention of recurrent stroke or MI. The population was adults, 18 years and over. The review included a total of 62 articles representing 44 studies for data abstraction. Transition of care interventions were grouped into four categories: (1) hospital-initiated support for discharge to home or intermediary care units such as inpatient rehabilitation or skilled nursing facilities; (2a) hospital-based patient and family education interventions; (2b) community-based patient and family education interventions; (3) community-based models of support interventions (most common); and (4) chronic disease management models of care (few). Studies were included from Norway, Germany, Canada, Australia, Iran, the UK, Italy, Mexico, Denmark, Netherlands, Poland, Finland and the US.

Results

Quality of life and hospital readmissions

- Early supported discharge as a component of hospital-initiated discharge planning (intervention type 1) after stroke was associated with a reduction

in total hospital length of stay without adverse effects on death or functional recovery (moderate strength of evidence).

- Specialty follow-up, a component of hospital-initiated support (intervention type 1), after MI and guideline-based practice were associated with a reduction in mortality (low strength of evidence).

- There was insufficient evidence to support a beneficial role for intervention types 3 or 4 in terms of improvement in functional status, quality of life and reduction in hospital readmission, morbidity and mortality.

- There was little consistency in the transition of care interventions from one study to another.

- There was much variability in the selection of outcome measures for evaluating the success of transition of care interventions.

Risks and potential harms

There was insufficient evidence to determine if there were differential rates of adverse events for transition of care interventions or components of transition of care services because rates for adverse events were similar for intervention and usual-care groups.

Service outcomes

- The use of emergency department services may be lessened by early education regarding stroke or MI symptoms (intervention type 2).

- Disease management programs may be more effective than remote phone calls for patients with MI (intervention type 3).

- Early return to work after MI may be safe and may be cost-effective from a societal perspective (intervention type 1). It did not seem to increase healthcare utilisation, and it may save the cost of cardiac rehabilitation in low-risk patients.

- Early supported discharge in low-risk stroke patients reduced hospital days and was thus cost-effective (intervention type 1). It did not increase burden on family providers (moderate level of evidence).

- Physician appointments or home visits by physical therapists may reduce readmission rates for stroke patients (intervention type 3). Visits by nurses did not produce the same effects (intervention type 3).
- Family support and case management services may reduce visits to physical therapists and specialists (intervention type 3).

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

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

Results:

Findings of effect

- Authors found that 'augmented DP' (discharge planning) appears to have a large effect on patient satisfaction (mean ES 0.83), moderate effects on QoL (.45) and readmission (.45), while only a small effect on function (.31) and length of stay (.26).
- Augmented discharge planning appears to have a robust effect on patient satisfaction and moderate effects on quality of life and hospital resources.
- No strong effects were noted for any one type of DP, patient characteristic, or quality assessment rating.

Findings on the evidence base

- In terms of study quality, inadequate reporting of methods and outcome data was evident in a considerable number of trials.
- Only 1 study could be located where the test intervention was social work coordinated.
- The authors point out that an important finding was the dearth of research evidence on the effect of social work coordinated discharge planning.

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

Outline: This is a moderate quality systematic review (+). It aimed to profile risk factors for adverse health outcomes for older patients discharged to their homes from an acute care setting. A second purpose was to identify and assess discharge assessment tools that could identify these risk factors a priori based on the premise that the current healthcare system is discharging elderly patients 'quicker'' and 'sicker' from acute care facilities. Consequently, hospital readmission is common; however, readmission may only be one aspect of adverse outcomes of importance to social work discharge planners. The early recognition of risk factors might ensure a successful transition from the hospital to the home.

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

Results

- Discharge factors were significantly associated with adverse outcomes post-discharge. A lack of documented family or patient education was found to significantly relate to readmission.
- Evidence indicated that need for healthcare information, health and concrete resource services, and emotional counselling were central to optimal discharges from hospital to home.
- Other significant factors revealed in the present review were limited social work involvement at admission, post-discharge patient distress and unresolved medical problems at discharge.

Risk factors

The most frequently cited risk factors associated with adverse health outcomes after discharge were depression, poor cognition, comorbidities,

length of hospital stay, prior hospital admission, functional status, patient age, multiple medications, and lack of social support.

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

16. Rennke et al (2013) Hospital-initiated transitional care interventions as a patient safety strategy

Outline: This systematic review of RCTs was judged to be of good quality and of moderate relevance to the UK context (++/+). It aimed to review evidence in the international literature on the effect of pharmacist-led interventions on post discharge clinical adverse events (AEs).

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

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

Two additional studies reported reductions in post discharge AEs with pharmacist-led medication safety interventions; findings were not statistically

significant, but both studies were underpowered to detect important differences between intervention and control groups.

Studies reporting views and experiences data (n=11)

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

Outline: This qualitative study of moderate quality (+) was designed to investigate discharge practice and the organisation of services at sites with consistently low rates of delay. The study was commissioned by the Department of Health prior to the introduction of the Community Care (Delayed Discharges) Act 2003. However, the Act was implemented before completion of the study, so it was redesigned to investigate: discharge planning and organisation of services prior to the Act; progress with implementation; and the impact of the Act on local discharge planning and organisation of services. Interviews with 42 health and social services staff involved in hospital discharge were conducted in 6 English sites. The proposed methodology involved service user interviews but the researchers were unable to secure sufficient participation. The authors were transparent about these and other problems encountered. Nevertheless, data collection and analysis could have been more robust.

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

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

Works well

Prioritisation of efforts to tackle delays at strategic and operational levels was common to all sites. Multi- and single-agency forums had been established at a senior level to monitor delays and take action to reduce rates. The

Community Care (Delayed Discharges) Act was a key driver of further activity, since it required intensive joint work to develop protocols, implement new systems, train staff and commission new or expand existing services.

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

Intermediate care services, involving a number of steps up and steps down to or from acute care were found to work well. In addition, a single intermediate care assessment team assessed patients for all intermediate care services, whether they were in A&E, in hospital or at home.

Having care managers attached to specific wards helps nurture the development of good relationships and communication between wards and social services. Where hospital-based teams had their own budgets for purchasing care, and dedicated 'placement officers' to identify vacancies in suitable residential homes and/or domiciliary care, care managers were able to focus entirely on care planning.

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

What helps

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

Makes it difficult

A lack of psychiatrists and community-based mental health services meant that older people with mental health difficulties were especially vulnerable to delays.

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

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

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

Outline: This is a moderate quality (+) phenomenological study, which aimed to investigate the experiences of older people on moving from hospital to an alternative location providing intermediate care prior to going home. Using face-to-face, semi-structured interviews the research question being explored was: did the intermediate care unit provide rehabilitation that met the needs of service users? Following the government's programme for improving services for older people as set out in the NHS Plan (Department of Health 2000) and the National Service Framework for Older People (Department of Health 2001), which introduced intermediate care as a central element, the study's findings are aligned to the underlying principles of intermediate care as set out in the document to support these initiatives.

Results:

- Users' experiences did not reflect the Department of Health's 4 principles that underpin the delivery of intermediate care: person-centred care; whole-system working; timely access to specialist care; promoting health and an active life.
- All users expressed satisfaction in respect of their stay (although caution should be taken when considering reported satisfaction with this age group). However, given the users' lack of understanding of the purpose of

the unit and the potential for their rehabilitation (as defined in the operational policy and external references to key characteristics of effective rehabilitation) this is perhaps unsurprising.

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

Outline: This low quality (-) study used mixed methods to attempt to resolve the problem of delayed hospital transfers in 1 English district. Researchers collected cross-sectional and qualitative data using hospital records and interviews with key informants. Triangulating these data, the researchers investigated the causes of delays. The records of 125 people aged 65 and over were included in the study and 6 middle managers, 3 from each of health and social services, were interviewed. Service user perspectives were obtained by way of a local Age Concern officer, an approach that the reviewers judge to be flawed. Although the authors do not explain their choice of mixed methodology, the methods are appropriate. However the interview respondents were limited in number and did not provide a good range of perspectives. Reported data were not 'rich'.

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

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

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

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

Makes it difficult

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

- awaiting decision about social service funding, 37 people (40.7 days)
- seeking of care home placement: by social services, 14 people (37.4 days) or privately, 15 people (20.1 days)
- family delays, 14 people (27.8 days)
- domiciliary care unavailable, 8 people (29.3 days)
- no sub-acute NHS bed, 9 people (23.7 days).

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

- shortages of health and social care professionals, including lack of provision of round-the-clock professional and care worker support for people returning to their own homes
- funding limitations, both inadequate resources at the disposal of social services to provide domiciliary care, and the high cost of residential placements
- confusion of responsibilities between health and social care agencies giving rise to poor coordination.

4. American Pharmacists Association and American Society of Health-System (2013) ASHP-APhA medication management in care transitions best practices

Outline: This review of best practice programmes is judged to be of low quality (-) and moderately relevant to the UK context (+). The review focuses on medication management in care transitions.

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

The assessment process focused on 3 main criteria:

- impact of the care transitions model on patient care
- pharmacy involvement in the transition process from inpatient to home settings
- potential to scale and operationalise the process for implementation by other health systems.

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

Results: Findings are presented under the relevant views and experiences questions:

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

Makes it difficult

Financial resources

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

Staffing resources

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

Communication

Barriers to communication during transition were reported between pharmacists and providers:

- inpatient and outpatient partners
- inpatient and outpatient pharmacists
- pharmacists and patients/caregivers
- pharmacists and administrative leadership.

Difficulty developing partnerships with inpatient or outpatient partners

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

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

Works well

Electronic transfer of patient information and data to partner groups

Those best practice programmes that had a bi-directional ability to view and augment electronic health records and had a distinct advantage in assisting educational efforts and communication of drug therapy.

Multidisciplinary support and collaboration

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

Effective integration of the pharmacy team

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

Data available to justify resources

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

- readmissions
- length of stay
- emergency department visits
- medication-related problems at medication reconciliation (for example, duplication of therapy)
- omission of needed drug therapy (correct drug but dosage too high or too low; drug interactions)
- disease-specific metrics
- patient satisfaction or Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) related metrics.

Electronic patient information and data transfer between inpatient and outpatient partners

In all these best practice programmes the ability to securely and efficiently transfer patient information was beneficial.

Strong partnership network

The alignment of resources was a keystone to providing a unified approach to patient care. Pharmacy partnerships involved hospital pharmacy departments, community pharmacies, regional pharmacy chains, ambulatory pharmacy services and clinics, health clinic pharmacies, home infusion pharmacies and many others.

5. Connolly, M., Grimshaw, J., Dodd, M., Cawthorne, J., Hulme, T., Everitt, S., Tierney, S. and Deaton, C. (2009) Systems and people under pressure: the discharge process in an acute hospital

Outline: This is a moderate quality (+) study designed to understand the perspective of hospital-based health professionals with regard to preparing patients for discharge from an acute hospital in England. Three focus groups were conducted and the data analysed using a framework approach. Eleven nurses participated, 15 allied health professionals, 5 social workers and 1 doctor. Analysis identified 2 broad themes and a number of sub themes:

- Conflicting pressures on staff:
    - keeping patients in hospital vs getting them out
    - striving for flexibility within a system
    - a paucity of intermediary provision.
- Casualties arising from conflicting pressures:
    - professionals losing their sense of professionalism
    - patients being 'systematised'.

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

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

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

Focus group members described feeling compelled to make discharge a swift procedure by managers and consultants, who were seen as striving to achieve government targets. Participants were keen for people to be allowed out of hospital as soon as they were ready, otherwise they risked acquiring an infection. However, they argued that this was not always possible when community services were required and that speed did not necessarily equate

with an effective discharge: '… there's lots of pressure on us from the government to get beds filled, to get the operation waiting list down etc. So the consultant asks 'why is this patient here? We need to get them out as soon as we can'' (p552) and '… the focus at the moment and this is where I'm quite appalled at the moment with dragging people through the system and identifying who could go and I feel it's quite sad because these are human beings ...' Professionals don't get time to think through how to address someone's range of needs and as a result patients come back again (readmission).

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

Works well

Multidisciplinary teams were seen as a way of avoiding communication difficulties.

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

Does not work well

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

Training in discharge procedures: junior staff teach incoming professionals, meaning competency gets weaker and weaker. Discharge is therefore not

something people learn about formally. There was a general sense of people not taking it seriously and a lack of clarity among professionals about whose responsibility it is and what role the different professionals should take.

Could improve transitions

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

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

Treating the whole person – some of the current procedures associated with discharge were depicted as dehumanising. For example, people were given labels such as 'medically fit for discharge', which oversimplifies cases and highlights that once the medical or 'acute' problem had been addressed, any remaining difficulties that patients experience are not regarded as the hospital's concern. An emphasis on a swift discharge was felt to overlook people's unique circumstances and prevent the establishment of an individual discharge path.

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

Helps

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

Makes it difficult

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

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

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

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

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

Could improve

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

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

Makes it difficult

- Aligning all parts of the discharge plan – 75% of practitioners agreed that waiting for 1 part of the discharge plan to be completed before another could commence was a problem.
- Moving patients between wards – according to 72% of respondents this causes discharge delays.

- Staffing levels – 44% of respondents felt there were inadequate staff to prepare patients for discharge.
- Government targets – 80% of respondents felt that performance targets placed on the hospital by government (for example, the target to limit the length of time any patient spends in the emergency department to 4 hours) could cause the discharge process to be hurried to accommodate new patients with the frequent result that the patients return to hospital within days.
- Tension between professional and family views – 87% of participants agreed that relatives could have an unrealistic expectation of services available.

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

Huby, G., Holt Brook, J., Thompson., A. and Tierney., A (2007) Capturing the concealed: inter-professional practice and older patients' participation in decision-making about discharge after acute hospitalization

Outline: Huby et al (2004) and Huby et al (2007) report findings from the same study, which was judged to be of good quality (++). It used mixed methods, including semi-structured interviews with 22 patients and 11 staff plus systematic observation of discharge planning over a 5-month period. Patients were recruited from 3 wards in a district general hospital in Scotland. They were purposively sampled to give variation in age (all 60 and over), gender, home circumstances (living alone or with carer), severity of condition (impact on daily life and prospects of recovery) and complexity of care (number of services needed on discharge). A follow-up home interview was conducted with 11 of the patients approximately 2 weeks after their discharge. The methods used in this study were judged appropriate.

The 2004 paper describes findings related to the analysis of the patient journey in which the authors identified the key drivers of discharge decision-making, whereas the 2007 paper relates more to decision-making in the

hospital setting. In fact, both papers describe the way that interprofessional working affects older people's participation in decisions about their discharge from hospital so the distinction between the papers is not as marked as the authors describe.

Results: The findings from the 2 papers are synthesised below and presented under the relevant views and experiences questions:

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

Both patients in the case studies described by Huby et al (2004) were withholding information and opinions from the professionals, which they themselves explained by their declining physical and mental powers. They felt the professionals (doctors especially) know best. They also equate making their opinions known with making a criticism, which they were keen to avoid. The researcher observed that this reluctance to express a view (or lack of encouragement to do so) resulted in neither patient having an influence on decisions around their treatment or discharge.

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

What could be improved

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

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

Does not work well

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

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

Makes it difficult

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

In both case studies a lack of available community services (home care) meant patients could not be discharged from hospital. Mrs B had to wait 'several weeks'. The delay also meant she was moved from the geriatric ward

(where the occupational therapist and physiotherapist are based) to a general ward 'where long term patients are sent for "boarding"' (Huby et al 2004 p125)

Hospital bed shortages were clearly on the minds of some of the patients interviewed who felt pressured into saying they felt well when they didn't. 'As I say they used to go round every day and say "well, Mr So-and-So's not bad we'll get him put out today and So-and-So can go tomorrow and that'll give us 2 beds vacant for other people to come in"' (Huby et al 2004 p128).

There were clear conflicts between the roles and responsibilities of different medical staff involved in the discharge process with consultants under pressure to prevent 'bed blocking' and nurses and Allied Health Professionals concerned with patients' functional ability and the potential risks of discharge. Nurses/AHPs were responsible for the practical discharge arrangements, which could take time, and often wanted to delay discharge beyond the 'clinically ready to go home' date. The hospital social worker was responsible for organising social care, such as home help, meals on wheels or a care home place and these resources were poorly resourced (Huby et al 2007).

8. Mold, F., Wolfe, C. and McKevitt, C. (2006) Falling through the net of stroke care

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

An earlier analysis of a population-based stroke register identified variations in provision of care. This study was carried out in order to investigate how these

differences might arise. Professionals highlighted deficiencies in the provision of stroke services but in so doing they also described the factors that they take into consideration when making decisions about referrals.

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

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

Does not work well

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

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

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

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

Makes it difficult

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

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

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

Outline: This is a moderate quality systematic review (+) that aimed to synthesise previous research investigating practices, perceptions and experiences of bedside staff nurses in relation to hospital discharge planning. Reports were included if the focus of the research was discharge planning for patients' transition from hospital to home and the role of the bedside nurse working in adult medical-surgical, intermediate care, or critical care units. Data relating to the nurse could reflect the perspectives of registered nurses, other non-nursing healthcare professionals, patients and patients' family members.

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

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

Could improve transition

Staff nurses and other direct care providers should strive to improve communication and working relationships by embracing a collaborative, team-based approach to patient-centred discharge planning.

The modification of end-of-shift reports to include a discharge preparation summary at each handover could improve verbal communication among nurses.

A second change designed to improve communication (written and electronic) is the use of critical pathways. Effective interagency communication can be accomplished through timely and comprehensive completion of standardised referral forms and creation of formal feedback system. Electronic decision support and discharge referral systems have the potential to facilitate effective communication among providers and agencies.

Findings revealed that bedside/staff nurse contributions to discharge planning are not highly visible in complex acute care environments dominated by technology and its related practices. Staff nurses should make every effort to organise patient care responsibilities, so they are able to actively participate in interdisciplinary rounds and discharge planning meetings.

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

Acute care bedside staff/nurses encountered the following barriers when preparing patients and families for transition from hospital to home:

- absent or ineffective verbal and written communication
- lack of integrated systems and structures
- insufficient time
- lack of continuity in patient care responsibilities
- knowledge that quickly needs updating
- role confusion.

10. Taylor, B. and Donnelly, M. (2006) Professional perspectives on decision-making about the long-term care of older people

Outline: This good quality (+) qualitative study investigated the perspectives of a range of health and social services staff on risk and decision-making regarding the long-term care of older people. The study was conducted in Northern Ireland, where 4 trusts were purposively sampled to represent each

of the 4 health and social services board areas, at least 1 'integrated' trust (i.e. providing both acute hospital and community services), at least 1 providing only community health and social services and at least 1 serving each of rural and urban areas. Participants were also purposively sampled and comprised of care managers, social workers, consultant geriatricians, general medical practitioners, community nurses, home care managers, occupational therapists and hospital discharge support staff. They participated in focus groups and in-depth interviews. The qualitative methods were judged to be appropriate to the aims of the study and data collection and analysis were reliable.

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

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

Does not work well

Participants described how decisions are taken to refer older people to institutional care on discharge from hospital. They described how these decisions are usually made in a crisis situation, for example due to 'societal factors'. Examples were given of a landlady not allowing an elderly tenant to return home after hospital. Other 'societal factors' include the lack of available public funding with only the most urgent cases receiving a publicly funded service, hence decisions were more likely to be taken in an emergency situation. The crisis nature of the situation increased the chance of people being admitted to residential care because there was less time to stimulate family support or set up a home care package, especially in rural areas.

The assessment of eligibility for residential care appears to be completely focused on people's physical needs rather their anxieties or emotional condition. For example, many respondents described the importance of people's 'fear of burglary' as a consideration for whether to refer them to residential care on discharge from hospital (as opposed to returning home).

Practitioners knew that fear of burglary couldn't be cited as a reason to refer to institutional care but when it was an issue they'd try to accommodate the person using 'social' criteria.

The availability and adaptability of services to meet identified needs was a key factor in decisions about the need for admission to long-term care. Practitioners were frustrated that home care workers were not allowed to undertake certain tasks even though family members do them with very little training. There was particular concern about meeting night care needs, and a perception that this could be critical in deciding on long-term care: 'The one thing that drives them into nursing homes is because they can't be left alone at night' (p817).

The availability of suitable staff to undertake home care work was an issue in some trusts as well as limitations in public funding: 'As has happened recently, the resources [public funding] have been there but the people haven't been there to do the work. In that situation they will end up in an institution' (GP, p819).

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

What helps

Respondents highlighted the importance of seeing beyond a person's condition or physical need in deciding whether to refer them for residential care. The way different people respond to their physical needs can vary. For instance, a fall may cause some people to become very anxious and lose confidence, dramatically changing their lifestyle, whereas others may not be affected.

Responses emphasised the importance of assessing people in their home and not only in the hospital environment. Whereas someone might appear to be at risk of falling because they are very unsteady in a ward environment (and therefore a candidate for referral to residential care), when they are

home they can move around their house more easily, often using 'furniture walking'.

What helps/makes it difficult

The availability, ability and willingness of a family member to provide care in these circumstances can both help the transition from hospital and make it difficult. 'You cannot assume because they are about or living in the same house that they will do this [provide care]' (social worker). Sometimes it was not so much the time or physical strength of carers that was an issue. Perhaps families could meet a range of care needs, but not more intimate needs because of their family relationship.

11. Turner, B., Ownsworth, T., Cornwell, P. and Fleming, J. (2009) Reengagement in meaningful occupations during the transition from hospital to home for people with acquired brain injury and their family caregivers

Outline: This moderate quality (+) qualitative study uses a prospective longitudinal design to explore people with acquired brain injury's (ABI) experiences of re-engagement in meaningful occupations during the hospital-to-home transitions phase. The study applied a phenomenological approach to address the following research questions:

- What occupations are most important to people with ABI and their family caregivers during the transition phase?
- How do people with ABI and their family caregivers perceive the process of re-engagement in meaningful occupations during the transition from hospital to home?

Semi-structured, in-depth interviews with both participants with ABI and their family caregivers were conducted at three time points during the transition phase: pre-discharge, and at 1 and 3 months post-discharge. The thematic data analysis process yielded 34 main categories, of which 8 were identified as having the most relevance to re-engagement in meaningful occupations.

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

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

Desired vs actual participation

Both participant groups identified that the occupations of most importance to them during the transition phase were returning to driving and work or education. However, for most participants with ABI, driving and work were only desired occupations, as opposed to actual occupations. This incongruity was a source of stress and frustration for many participants with ABI.

Many reported that they did not understand why they were not able to participate in these occupations or why it was taking so long to return to active participation in these occupations. Participants reported feeling uninformed or ill informed (ie received conflicting information) concerning the process of returning to driving and work or education.

Struggle for independence

Returning home was typically seen by participants with ABI as a newfound freedom; they were excited at the prospect of discharge and were relieved when the time came. However, certain barriers and restrictions – including both formal and informal constraints – hampered their pursuit of independence, and their perceived freedom was often short-lived.

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

People with ABI and family caregivers wanted more information or education on the following areas:

- the process of returning to work or education and driving
- ways to establish routines and structure one's time
- ways for managing stress and frustration

- ways to cope with formal and informal restrictions.

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

Occupational therapy practice

Occupational therapists need to establish meaningful yet realistic client-centred goals. Therapists need to ensure they do not promote false hope by ensuring the client's desired occupations are validated and incorporated into the development of therapy plans.

Key elements which are integral to early transitions success for people with ABI and their caregivers

Facilitating recovery through participation; fostering feelings of usefulness; enhancing people's use of time; and assisting people in managing perceived restrictions.

Studies reporting evidence of cost-effectiveness (n=9)

People with stroke

Evidence from 1 systematic review and meta-analysis (Fearon and Langhorne 2012, 14 trials, 8 from UK ++) showed that early supported discharge with multidisciplinary community care (ESD-MCC) for people with stroke led to a reduction in length of hospital stay (7 days, p<0.0001, n=1,695) but not in the risk of hospital readmission (31 vs 28%, n=918); a reduction in care home admission (OR=0.78, p=0.05, n=1,758); a reduction in short-term dependency (OR=0.80, p=0.02, n=1,957) and an increase in extended ADL (standard mean difference 0.15, p=0.02). Effects varied by severity of needs with clinical outcomes improving more for people with mild and moderate needs and reductions in hospital bed days being greater for people with high needs. Findings from 7 studies (including 2 UK studies) suggested that costs were reduced when direct and indirect costs were included and that costs of the intervention were likely to be offset by the reduction in hospital bed days.

This was confirmed by 2 systematic reviews which were both of moderate quality with potentially serious limitations (Larsen et al 2006 +; Brady et al 2005 +). They found that ESD-MCC had lower costs or was cost neutral if it was compared to conventional care including hospital rehabilitation; 1 of the reviews suggested that reductions in costs were achieved when ESD-MCC was provided in a stroke unit. Compared with stroke unit alone ESD-MCC achieved reductions in total costs, linked to a significant reduction in care home admissions (OR=0.45, CI 0.31-0.96, n=1,108) and hospital length of stay (10 days, CI 2.6-18, n=1,108). Studies in this area did not measure the impact on health and social care services in the community so that a conclusion about total costs could not be drawn.

Findings from one UK cost-utility decision modelling study (Saka et al 2009 ++) suggest that a stroke unit with early supported discharge had better outcomes (health-related quality of life) and higher costs than a stroke unit without early supported discharge and was altogether more cost-effective with an ICER of under £20,000 per QALY (measured over 10 years).

A cost-utility study carried out alongside an RCT (Patel et al 2004 ++, n=457) compared three strategies, stroke unit, stroke team in general ward and stroke care at home, and found that stroke unit care was linked to a reduced risk of care home admission (14, 30 and 24%, p<0.03) and better chance of survival without disability at 1 year (85, 66 and 71%, p<0.001). Total health and social care costs were highest for stroke unit care and lowest for stroke care at home. Informal care costs were substantial but did not change the order of cost findings. QALYs were measured via the EQ-5D and it is reported that stroke care provided at home was the most cost-effective strategy. Findings have to be interpreted in the context of the UK system at the time when the studies were carried out (in the late 1990s) and stroke care was significantly less developed.

Older people

A UK-based cost utility study (Miler et al 2005 ++, n=272) evaluated an early discharge and 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-hour 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 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.

A cost-utility study carried out alongside an RCT in Finland (Hammar et al 2009 ++, n=668) compared case management organised through a nurse-support worker partnership with standard care. The study found better health-related quality of life outcomes in the intervention group at baseline and 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 scores on the Nottingham Health Profile in the intervention at 6 months follow-up and non-significant reduction in total health and social care costs (in euros, 2001 prices; T=0 2,831, SD 2,655 vs 2,722, SD 2,691; T=1 6,678, SD 5,574, vs 7,773, SD 6,884). Figures showed that the intervention was highly likely to be cost-effective at willingness to pay thresholds of £20,000 to £30,000. The ICER for EQ-5D ranged from €10,951 to €12,274 (£6,899 to £7,733).

A cost-effectiveness study carried out alongside a RCT in Australia (Lim et al 2004 ++, n=598) compared health professional-led discharge planning and case management with budget for community services with routine care. Individuals in the intervention group showed greater improvements in independent living (p=0.002) and quality of life (p=0.02). There were no significant differences in other outcomes such as mortality, carers' stress, unplanned readmission and emergency department visits. Results were not presented in combined form but the authors concluded that the intervention

appeared to be beneficial, led to an improvement in quality of life and a reduction in healthcare costs.

A cost utility study carried out alongside an RCT in Hong Kong (Wong et al 2012 +, n=555) compared case management organised through a nurse-volunteer partnership with standard care and found significantly lower hospital readmission rates at 28 and 84 days (4 vs 10.2%, 8.1 vs 19.4%, p-value not reported) and health-related quality of life gains at 28 days (p<0.001) and 84 days (p<0.001). Total changes in costs were not reported; cost-effectiveness acceptability curves were presented that showed that the intervention had a 65 and 95% chance of savings costs at 28 and 84 days and an 89% chance of being cost-effective at a willingness-to-pay threshold of £20,000.

Evidence statements (including economic evidence statement)

HD1	There is a moderate amount of moderate quality evidence that improved interprofessional 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 standardised 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.
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. 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 healthcare worker acting as discharge coordinator.
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. 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.
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, 2 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.
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 dehumanising'. 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.
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 -) and 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, 1 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 in caregivers' emotional coping for depression, anxiety and worry and no reduction in the amount of caregiving; the only differences were less role strain and caregiver preparedness to participate in post-hospital care.
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 1 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 multidisciplinary community care is likely to be cost-effective when compared with standard care. One UK cost-utility study carried alongside an 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 that 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 4 full economic evaluations carried out in different countries, including 1 UK study (Miller et al 2005). The studies were carried out alongside RCTs 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 multidisciplinary team in the UK (Miller et al 2005 ++ n=272). Findings from all 4 studies suggested that early supported discharge in combination with rehabilitation improved physical health and reduced costs and was likely to be cost-effective.

Included studies for hospital discharge review questions (full citation)

Bahr S, Solverson S, Schlidt A et al (2014) Integrated Literature Review of Post-discharge Telephone Calls. Western Journal of Nursing Research 36: 84–104

Baumann M, Evans S, Perkins M et al (2007) Organisation and features of hospital, intermediate care and social services in English sites with low rates of delayed discharge. Health & Social Care in the Community 15: 295–305

Benten J and Spalding N (2008) Intermediate care: what are service users' experiences of rehabilitation? Quality in Ageing - Policy, Practice and Research 9: 4–14

Brady BK, McGahan L, Skidmore B (2005), Systematic review of economic evidence on stroke rehabilitation services, International Journal of Technology Assessment in Healthcare, 21:1: 15-21.

Bryan K, Gage H, Gilbert K et al (2006) Delayed transfers of older people from hospital: causes and policy implications. Health Policy 76: 194–201

Burton C and Gibbon B (2005) Expanding the role of the stroke nurse: A pragmatic clinical trial. Journal of Advanced Nursing 52: 640–50

American Pharmacists Association and American Society of Health-System (2013) ASHP-APhA Medication Management in Care Transitions Best Practices

Chhabra P, Rattinger G, Dutcher S et al (2012) Medication reconciliation during the transition to and from long-term care settings: A systematic review. Research in Social and Administrative Pharmacy 8: 60–75

Conroy S, Stevens T, Parker S et al (2011) A systematic review of comprehensive geriatric assessment to improve outcomes for frail older people being rapidly discharged from acute hospital: 'interface geriatrics'. Age and Ageing 40: 436–443

Connolly M, Deaton C, Dodd M et al (2009) Systems and people under pressure: The discharge process in an acute hospital. Journal of Clinical Nursing 18: 549–58

Connolly M, Deaton C, Dodd M et al (2010) Discharge preparation: do healthcare professionals differ in their opinions? Journal of Interprofessional Care 24: 633–43

Fearon P and Langhorne P (2012), Services for reducing duration of hospital care for acute stroke patients. Cochrane Database of Systematic Reviews: Reviews 2012; Issue 9.

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

Fox M, Persaud M, Maimets I et al (2013) Effectiveness of early discharge planning in acutely ill or injured hospitalized older adults: a systematic review and meta-analysis. BMC Geriatrics 13: 1–9

Hammar T, Rissanen P, Peraelae ML (2009), The cost-effectiveness of integrated home care and discharge practice for home care patients, Health Policy 92:10-20.

Hesselink G, Schoonhoven L, Barach P et al (2012) Improving patient handovers from hospital to primary care: a systematic review. Annals of Internal Medicine 157: 417–28

Huby G, Stewart J, Tierney A et al (2004) Planning older people's discharge from acute hospital care: linking risk management and patient participation in decision-making. Health, Risk & Society 6: 115–132

Huby G, Brook J, Thompson A et al (2007) Capturing the concealed: Interprofessional practice and older patients' participation in decision-making about discharge after acute rehospitalisation. Journal of Interprofessional Care 21: 55–67

Larsen T, Olsen T, Sorensen J (2006) Early home-supported discharge of stroke patients: a health technology assessment. International Journal of Technology Assessment in Healthcare 22: 313–20

Laugaland K, Aase K, Barach P et al (2012) Interventions to improve patient safety in transitional care - a review of the evidence. Work 41: 2915–24

Li H, Powers B, Melnyk B et al (2012) Randomized controlled trial of CARE: An intervention to improve outcomes of hospitalized elders and family caregivers. Research in Nursing & Health 35: 533–49

Lim W K, Lambert S F, Gray L C. (2003), Effectiveness of case management and post-acute services in older people after hospital discharge. Medical Journal of Australia; 178(6): 262-266.

Lindpaintner L, Gasser J, Schramm M et al (2013) Discharge intervention pilot improves satisfaction for patients and professionals. European journal of internal medicine 24: 756–62

Miller P, Gladman J R, Cunliffe A L, Husbands S L, Dewey M E, Harwood R H. (2005), Economic analysis of an early discharge rehabilitation service for older people. Age and Ageing; 34(3): 274-280.

Mold F, Wolfe C, McKevitt C et al (2006) Falling through the net of stroke care. Health & Social Care in the Community 14: 349–56

Newcomer R, Kang T, Graham C et al (2006) Outcomes in a Nursing Home Transition Case-Management Program Targeting New Admissions. The Gerontologist 46: 385–90

Nosbusch J, Weiss M, Bobay K (2011) An integrated review of the literature on challenges confronting the acute care staff nurse in discharge planning. Journal of Clinical Nursing 20: 754–74

Olson DW, Bettger J, Alexander K et al (2011) Transition of care for acute stroke and myocardial infarction patients: from rehospitalisation to rehabilitation, recovery, and secondary prevention. Evidence Report/Technology Assessment (202) 1–197

Patel A, Knapp M, Perez I, Evans A, Kalra L (2004), Alternative strategies for stroke care: cost-effectiveness and cost-utility analyses from a prospective randomized controlled trial. Stroke; 35(1): 196-203

Preyde M, Macalay C, Dingwall T et al (2009) Discharge planning from hospital to home for elderly patients: a meta-analysis. Journal of Evidence-Based Social Work 6: 198–216

Preyde M and Brassard K (2011) Evidence-based risk factors for adverse health outcomes in older patients after discharge home and assessment tools: a systematic review. Journal of Evidence-Based Social Work 8: 445–68

Rennke S, Nguyen O, Shoeb M et al (2013) Hospital-Initiated Transitional Care Interventions as a Patient Safety Strategy. Annals of Internal Medicine 158: 433–40

Saka O, Serra V, Samyshkin Y, McGuire A, Wolfe C C (2009), Cost-effectiveness of stroke unit care followed by early supported discharge. Stroke 2009; 40(1): 24-29

Taylor B and Donnelly M (2006) Professional Perspectives on Decision Making about the Long-Term Care of Older People. The British Journal of Social Work 36: 807–26

Turner B, Ownsworth T, Cornwell P et al (2009) Reengagement in meaningful occupations during the transition from hospital to home for people with acquired brain injury and their family caregivers. American Journal of Occupational Therapy 63: 609–20

Wong FK, Chau J, So C, Tam SK, McGhee S (2012), Cost-effectiveness of a health-social partnership transitional program for post-discharge medical patients, BMC Health Services Research, 12:479.

3.5 Reducing (30-day) readmissions to hospital

Introduction to the review questions

The purpose of these review questions was to examine the effectiveness and cost-effectiveness of health and social care interventions designed to reduce a hospital readmission within 30 days of the person being discharged from hospital. The questions also aimed to consider research, which systematically collected the views of people using services, their carers, and care and support staff in relation to approaches and interventions designed to reduce hospital readmissions within 30 days of discharge.

Overall, a good amount of evidence about the impact of interventions to reduce hospital readmission was located and reviewed and this included evidence of cost-effectiveness. The quality of the evidence was mostly good. Some of the studies included in the 'improving hospital discharge' review area

could arguably have been used to answer the hospital readmissions question and vice versa. This is because many of the evaluations of interventions for improving hospital discharge use 'readmission rates' as an outcome measure. A successful hospital discharge is routinely indicated by there being no readmission within 30 days. For studies to be included in the reducing readmissions review, 'readmissions' had to be the stated primary outcome. The interrelatedness of the two review areas is demonstrated by one of the hospital discharge studies (Bahr et al 2004) informing one of the evidence statements about reducing readmissions (RHR2).

The amount and quality of effectiveness and cost-effectiveness studies was contrasted by views and experiences data, which were not reported in any included papers.

Review question for evidence of effectiveness

7. What is the effectiveness of interventions and approaches designed to reduce hospital readmissions within 30 days of hospital discharge?

Review questions for evidence of views and experiences

Review questions 1–4 and question 10, listed on pages 2–3, were applied specifically in relation to interventions or approaches for reducing readmissions.

Summary of review protocol

The protocol sought to identify studies that would:

- identify the effectiveness of health and social care interventions designed to reduce the likelihood of a person being readmitted within 30 days of hospital discharge
- identify emerging models of care, assessment and discharge planning which demonstrated reduction in readmissions within 30 days of hospital discharge
- assess the cost-effectiveness of interventions designed to reduce hospital readmissions.

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

- describe the self-reported views and experiences of adults with social care needs, their families and unpaid carers about the care and support they receive during interventions or approaches designed to reduce hospital readmissions
- highlight aspects of care and support during the hospital admission and discharge process that work well, as perceived by service users, their families and unpaid carers, and aspects of care and support during discharge from hospital which are perceived not to work well in terms of reducing readmissions
- describe the views and experiences of people delivering, organising and commissioning social care, health and housing services
- highlight aspects of the hospital admission and discharge process which work well, and are personalised and integrated, as perceived by practitioners, managers and commissioners, and aspects which should be changed to reduce readmissions
- contextualise the views of users, carers and practitioners by identifying barriers and facilitators to improved or changed practice they suggest would improve outcomes relating to hospital readmissions.

Population: adults, aged 18 years and older, with social care needs who are transferring from inpatient hospital settings or intermediate care to community or care home settings. Self-funders and people who organise their own support and who are transferring from inpatient hospital settings or intermediate care to community or care home settings.

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

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

Setting: Bed-based intermediate care settings ('step down' or 'step up') and service user's home, including sheltered housing accommodation; supported housing; temporary accommodation; care (residential and nursing) homes.

Outcomes: User- and carer-related outcomes (such as user and carer satisfaction; quality and continuity of care; choice and control; involvement in decision-making about place of death and health and social care-related quality of life) and service outcomes such as use of health and social care services, unplanned or inappropriate admission, emergency hospital (re)admissions (see 4.4 in the scope).

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

The study designs included for the effectiveness questions on reducing hospital readmissions were:

- systematic reviews of studies of different models of intermediate care, assessment and planning

- RCTs of different approaches to bed based intermediate care, assessment and care planning

- controlled studies of different approaches to bed-based intermediate care, assessment and care planning

- economic evaluations.

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

- systematic reviews of qualitative studies on this topic

- qualitative studies of user and carer views of social and integrated care

- qualitative components of effectiveness and mixed methods studies

- observational and cross-sectional survey studies of user experience.

Full protocols can be found in Appendix A.

How the literature was searched

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

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

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

Searches were also rerun in June 2015 and a summary of the studies for this review area can be found in Section 3.8.5

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

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs –

and screened against an exclusion tool informed by the parameters of the scope. Formal exclusion criteria were developed and applied to each item in the search output, as follows:

- language (must be in English)
- population (must be over 18 years of age and have a social care need)
- transition (a transition into or out of an inpatient hospital setting must have occurred within the last 30 days)
- intervention (must be involved in supporting transitions)
- setting (inpatient hospital setting, intermediate care setting, community setting or care home)
- country (must be UK, European Union, Denmark, Norway, Sweden, Canada, USA, Australia or New Zealand)
- date (not published before 2003)
- type of evidence (must be research)
- relevance to (one or more) review questions.

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

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

In our initial screen (on title and abstract), we found 583 studies which appeared relevant to the review questions on improving hospital discharge and reducing readmissions. We ordered full texts and reviewed 183 papers for final inclusion. For views and experiences research, studies from a UK setting were prioritised. Effectiveness studies were restricted to systematic reviews, RCTs or controlled studies. On reviewing the full texts, we identified 11 which fulfilled the criteria (see included studies below) and related specifically to

reducing hospital readmissions, plus 3 economics studies. The included studies (see below) were critically appraised using NICE tools for appraising different study types, and the results tabulated. Further information on critical appraisal is given in the introduction at the beginning of Section 3. Study findings were extracted into findings tables. For full critical appraisal and findings tables, see Appendix B.

Narrative summaries of the included evidence

Studies reporting effectiveness data (n=11)

1. Allen J, et al (2014) Quality care outcomes following transitional care interventions for older people from hospital to home: a systematic review

Outline: This is a good quality (++) systematic review, which is moderately relevant to the review area. It aimed to synthesise RCTs examining the outcomes of transitional care interventions compared with standard hospital discharge for older people with chronic illnesses. It also sought to make recommendations for research and practice. Included studies were published in a peer-reviewed journal, and reported transitional care compared with standard hospital discharge. They used a randomised control design, were published in English and provided an analysis of outcomes evaluating quality indicators relating to older people. Twelve papers met the inclusion criteria. Although they matched the scope on intervention and population, half the papers were published before our 2003 cut-off date and none were UK studies; they were from the US, Australia, Denmark and France.

Results: In 6 studies (out of 11 with re-hospitalisation as an outcome), significant reductions in re-hospitalisation rates were found for people in the intervention groups at up to 6 months following hospital discharge and at up to 3 months following discharge in the study by Legrain et al. (Findings are highlighted here from studies published 2003 onwards. Full findings can be found in the evidence tables.)

- Advanced practice nurse delivered transitional care (Naylor 2004):

- at 52 weeks, intervention patients had fewer re-hospitalisations and lower total mean costs

- there were short-term improvements among intervention patients in quality of life (physical domain) up to 12 weeks post discharge and satisfaction with discharge and transition care (up to 6 weeks post discharge).

- Brief nurse practitioner intervention for 3 months following discharge (Enguidanos 2012):

  - no change in re-hospitalisation rates at 6 months following enrolment in the study

  - the intervention group experienced significantly fewer visits to GPs

  - no changes between intervention and control groups in self-efficacy or satisfaction with service.

- Hospital coordinated discharge plan involving GP (Preen 2005):

  - no differences in length of stay between groups; intervention group reported improved satisfaction with discharge planning, access to health services, confidence with discharge and 'mental quality of life' 1 week following discharge.

- Self-management and transition coaching (Coleman 2006):

  - the intervention group had significantly lower re-hospitalisation rates than the control group at 30, 90 and 180 days post-discharge

  - the intervention group had significantly lower hospital costs than the control group at 30, 90 and 180 days post discharge.

- Discharge case management (Lim 2003):

  - over a 6-month follow-up period there were no differences in rates of unplanned re-hospitalisations

  - intervention patients had significantly reduced length of stay (index hospitalisation)

  - costs (hospital utilisation) were lower in intervention patients over 6 months following discharge; no differences in costs (utilisation of community services) between groups

  - significantly improved self-reported quality of life in intervention patients at 1-month follow-up

- no difference in caregiver burden at 1-month follow-up.

- Inpatient geriatric evaluation, co-management (with ward staff) and transitional care (Legrain 2011):
  - intervention group were significantly less likely to attend the emergency department or be re-admitted at 3 months following discharge
  - no differences between groups in emergency department attendances or re-hospitalizations at 6 months following discharge.

2. Hansen, L., Young, R., Hinami, K., Leung, A. and Williams, M. (2011) Interventions to reduce 30-day rehospitalization: a systematic review

Outline: This is a good quality systematic review (++) that aimed to provide an inventory of interventions studies to reduce re-hospitalisation within 30 days and describe the best-published evidence for the effectiveness of these interventions. Included studies were from the US, Israel, Canada, the Netherlands, Hong Kong, Ireland, Portugal, New Zealand, Denmark, Belgium, Australia and Taiwan.

Results: Authors identify 3 types of interventions to reduce hospital admissions:

- pre-discharge interventions, comprising of patient education, discharge planning, medication reconciliation, appointment scheduled before discharge
- post-discharge interventions, comprising of timely primary care provider communication, timely clinic follow-up and follow-up telephone calls, post-discharge hotline, home visits
- interventions bridging the transition including transitional coach, patient-centred discharge instructions and provider continuity.

Few studies in the systematic review studied only 1 component of a discharge care plan, and were a collection of different components. Ten RCTs did not find significant effects of isolated or bundled interventions overall, when negative effects were included.

There were 5 RCTs (out of a total of 16) that documented statistically significant improvements in re-hospitalisation outcomes within 30 days. One study compared early discharge planning to usual care with the treatment group experiencing an 11 percentage point reduction in 30-day readmissions. The remainder of the studies looked at multi-component interventions. Interventions common to the 4 studies were the post-discharge telephone calls and patient-centred discharge instructions (PCDIs). However 2 RCTs that included these interventions did not report significant effects, and 2 studies that looked at follow-up calls in isolation did not find a significant effect.

3. Hung, W.W., Ross, J.S., Farber, J. et al (2013) Evaluation of the mobile acute care of the elderly (MACE) service

Outline: This is a moderate quality (+) matched cohort study which evaluated the impact of the mobile acute care of the elderly (MACE) service on patients aged 75 years or older admitted to hospital for an acute illness. A total of 173 matched pairs were recruited. MACE is a model of care for hospitalised older adults, delivering specialised care, such as early mobilisation, minimisation of procedures, medication review, attention to geriatric syndromes and enhanced discharge planning to older adults wherever they are located within the hospital. Specifically, MACE consists of a geriatric hospitalist who serves as the primary hospital provider, along with a geriatrics fellow, a clinical nurse specialist and a social worker.

The usual care team did not have a geriatrician or a clinical nurse specialist. In addition, they had a unit-based social worker rather than a team-based social worker. Data were obtained on admission and at 15 and 30 days post-discharge by a clinician who was not blinded to the allocation groups.

Results: while the MACE service was not associated with any significant reduction in readmission rates at 30 days it was associated with better outcomes in several important areas when compared with usual care. The MACE service was associated with lower rates of adverse events, shorter lengths of stay and improved satisfaction on transitions of care when measured on the Care Transition Measure. These findings suggest that

providing inpatient care through a MACE service may be associated with better outcomes for this vulnerable older adult population.

The authors state that the MACE model may be a viable alternative to dedicated units or floors for the care of older adults. It can be integrated in a hospital's workflow without the requirement of a dedicated unit. The only new role that requires staffing is the nurse coordinator, as the social worker and geriatrics physician are obtained by reallocating existing resources.

4. Jacob, L (2008) Systematic review: predictors of successful transition to community-based care for adults with chronic care needs

Outline: This is a moderate quality (+) systematic review of care management strategies to support transition from acute care back to the community. Studies were grouped into one of two broad categories: studies of patient characteristics and/or of discharge support interventions. The review meta-synthesised qualitative research findings in order to identify which patients are susceptible to difficult transitions, and to understand strategies to reduce risk of unplanned readmission. Successful transition was defined as reduced acute care readmission, reduced emergency department use and reduced mortality. Some studies attempted to use improved quality of life as an outcome but this proved poorly defined and difficult to quantify.

Results

- there is support for enhanced discharge support in preventing or delaying hospital readmissions in the presence of specific discharge diagnoses, specifically heart failure and stroke
- there is little evidence that enhanced discharge support is related to improved physical status at home
- lapses in discharge planning may affect patients' perceptions of readiness for discharge, which may affect actual discharge success

- those with adequate social support and confidence in self-care ability tend to experience fewer readmissions than do those living alone and those who perceive themselves as not ready to return home.

5. Leppin, A.L (2014) Preventing 30-day hospital readmissions: a systematic review and meta-analysis of randomized trials

Outline: This is a good quality (++) systematic review that assessed the effectiveness of peri-discharge interventions versus any comparator on the risk of early (within 30 days of discharge) all-cause or unplanned admissions and readmissions. In addition, the review sought to identify intervention features – including their impact on treatment burden and on patients' capacity to enact post discharge self-care – that might explain their varying effects. Included studies were from the US, Croatia, Hong Kong, Switzerland, Denmark, Israel, Australia, Sweden, Belgium, New Zealand, the Netherlands, England, Taiwan, Germany and Canada. The aims and outcomes of the review are clearly stated and each trial was assessed for risk of bias using a standardised form based on the Cochrane Collaboration's tool.

Results

- The body of randomised trial evidence shows a consistent and beneficial effect of tested interventions on the risk of 30-day readmissions.
- Interventions that used a complex and supportive strategy to assess and address contextual issues and limitations in patient capacity were most effective at reducing early hospital readmissions. Many of these contacted the patient frequently, used home visits and reported cost savings.
- Findings showed that more recently tested interventions were less effective.

6. Linertová, R., Garcia-Perez, L., Vazquez-Diaz, J., Lorenzo-Riera, A. and Sarria-Santamera, A. (2011) Interventions to reduce hospital readmissions in the elderly: in-hospital or home care. A systematic review

Outline: This is a good quality (++) systematic review to identify effective interventions for reducing the risk of hospital readmissions in patients aged 75

years and older. The role of home follow-up was a particular focus. Eligible studies were controlled trials of an intervention conducted during hospital admission or follow-up. Hospital admission could be for any reason. Trials had to report the outcome of unplanned readmission to hospital. The review included 32 clinical trials, which were divided into 2 groups: in-hospital interventions (17 studies) and interventions with home follow-up (15 studies). Thirteen of the 32 studies were published before our cut-off date (2003) but population and interventions were within scope. The review is therefore judged to have good external validity.

Results

In-hospital geriatric evaluation and discharge management

- In 3 (out of 17 studies) in-hospital treatment produced statistically significant differences to the control group in terms of reduced readmissions (the 3 interventions were: intermediate care at a community hospital; a 'targeted care bundle'; and inpatient community- based geriatric assessment).
- A negative effect was observed in 1 inpatient study (geriatric evaluation and management consultation services in frail hospitalised patients) and the remainder did not show any effect of the interventions evaluated on the risk of hospital readmission.

Geriatric assessment with home follow-up

The effectiveness of home follow-up interventions was demonstrated in 7 clinical trials (out of 15), 2 of them only partially depending on the follow-up period, while in 1 study a negative effect on readmission rate was described. The remainder of the studies did not show any effect of the intervention on readmissions.

- Among the studies reporting positive effects, a comprehensive geriatric assessment followed by home care provided by a hospital-based multidisciplinary outreach team was evaluated. This study showed that patients in the intervention group had a lower rate of hospital readmissions during the first 30 days, together with a lower rate of emergency

admissions and a longer time to the first emergency admission. Interventions that incorporate geriatric management supported with home care post discharge are more likely to reduce or prevent hospital readmissions in elderly patients. The services are complex requiring a high degree of collaboration and communication between patients, caregivers, geriatricians, GPs, social community services and other agents. Specific features of the interventions are patient education on specific issues, close follow-up, home monitoring, adjustment of medication and regular communication with clinical experts. Therapeutic success in many instances rests more on effective patient targeting than on setting, intensity or duration of the interventions.

7. Naylor, M. (2011) The importance of transitional care in achieving health reform

Outline: This is a low quality (-) systematic review, which is moderately generalisable. It aimed to identify and synthesise available evidence regarding transitional care for adult, chronically ill populations and, particularly, to recommend strategies to guide the implementation of transitional care under the Affordable Care Act.

The inclusion criteria for transitional care was defined as 'a broad range of time-limited services designed to ensure healthcare continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one 1 level of care to another or from one type of setting to another'.

Results: Studies of 9 interventions demonstrated a positive effect on at least 1 measure of readmissions; 8 of the 9 reduced all cause readmissions through at least 30 days after discharge. Among these 9 interventions, the average length of the post-discharge portion was 6 and a half weeks. However, 3 more effective interventions, which demonstrated reductions in readmissions through 6 or 12 months, averaged more than 9 weeks post discharge in length.

- All 9 interventions that showed any positive impact on readmissions relied on nurses as the clinical leader or manager of care.
- Six of the 9 studies that demonstrated a positive effect on at least 1 measure of readmission included in-person home visits.
- Two types of multicomponent interventions have proved more effective in reducing all-cause readmissions:
  - comprehensive discharge planning with follow-up interventions that incorporate patient and caregiver goal setting, individualised care planning, educational and behavioural strategies, and clinical management
  - a tele-health facilitated intervention emphasising daily home videophone or telephone monitoring and transmission of physiologic measurements, self-care instruction and symptom management.
- Each of the 3 studies that effectively reduced readmissions through at least 6 or 12 months after discharge included a focus on patient self-management.

8. Sadowski, L., Kee, R., VanderWeele, T. and Buchanan, D. (2009) Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: a randomized trial

Outline: This is a moderate quality (+) RCT of moderate relevance to the UK context. The aim of this study was to assess the effectiveness of a case management and housing programme in reducing use of urgent medical services among homeless adults with chronic medical illnesses. Housing was offered as transitional housing after hospital discharge, followed by placement in long-term housing.

The homeless population was one that was considered by the equality impact assessment to be particularly vulnerable in the transition from hospital to the community. This US study offers a unique perspective in attempting to address the issues of having no home to transition to.

Results: Adjusted for baseline characteristics, the intervention groups had statistically significantly lower rates of:

- hospitalisations
- hospital days
- emergency department visits.

However, at 18 months there was no significant differences between groups on health-related quality of life measures.

9. Schwarz, K., Mion, L., Hudock, D. and Litman, G. (2008) Telemonitoring of heart failure patients and their caregivers: a pilot randomized controlled trial

Outline: This is a good quality (++) RCT designed to examine the effects of tele-monitoring by an advanced practice nurse on older heart failure patients. The outcomes included impact on social support, a range of clinical outcomes, subsequent hospital readmissions, emergency department visits, costs and risk of hospital readmission for patients with heart failure. Caregiver outcomes were also measured with patient and caregiver dyads assigned to the intervention and control. The intervention group received an electronic home monitoring (EHM) system, which recorded their weight on a daily basis and collected other subjective data about physical symptoms. The 'Cardiocom EHM system' was installed at the first interview and removed by the nurse 90 days later, at the second interview. 'Usual care' was not described. The methods of evaluation were judged appropriate and the study is relevant to the scope.

Results

- Hospital readmissions, emergency department visits and costs of care between groups:
  - there was no difference in hospital readmission between the intervention (n=12) and usual care (n=13) groups ($x2=0.27$; $p=.60$)

- hospital charges alone did not differ significantly between intervention and usual care groups ($10,996.86±$29,230.05; $5,462.58±$9,825.00, respectively; p=.26)

- out-of-pocket costs for medications, physician office visits and laboratory testing were similar between groups

- there was no significant difference in emergency department visits between groups.

- Depressive symptoms, days to readmission, quality of life, caregiver mastery between groups:

  - while differences existed between groups at baseline with regard to caregiver mastery, there were no differences between groups for any outcome at the 90-day follow-up visit

  - for those readmitted to hospital, the number of days to readmission did not differ significantly between groups

  - there was no significant difference in quality of life scores between groups at the 90-day follow-up visit.

- Caregiver mastery, informal social support and tele-monitoring as predictors of reduced hospital readmission:

  - Cox proportional hazards regression modelling was used to identify independent predictors of risk for hospital readmission in days; independent variables included caregiver mastery, informal social support and tele-monitoring. None of these predicted risk of hospital readmission.

10. Scott, I.A (2010) Preventing the rebound: Improving care transition in hospital discharge processes

Outline: This is a good quality (++) systematic meta-review, which included only systematic reviews and controlled studies. The aim was to determine the relative efficacy of peri-discharge interventions categorised into two groups: (1) single component interventions (sole or predominant) implemented either

before or after discharge; and (2) integrated multi-component interventions, which have pre- and post-discharge elements.

Results

- Intense self-management and transition coaching of patients at high risk of readmission, and the use of home visits or telephone support for patients with heart failure, appear to be the only single-component strategies that demonstrated consistent evidence of efficacy in reducing readmissions.
- Trials involving integrated multi-component strategies that span the pre-discharge/post-discharge continuum are limited in number but appear to show positive outcomes in reducing readmissions.
- The evidence suggests that discharge processes are effective in reducing readmissions if they include the following components:
  - early and complete assessment of discharge needs and medication reconciliation
  - enhanced patient (and caregiver) education and counselling specifically focused on gaining an understanding of the patient's condition and its self-management
  - timely and complete communication of management plan between clinicians at discharge when patient care is transferred from hospital staff to primary care teams
  - early post-acute follow-up within 24–72 hours for high-risk patients with either doctor or nurse
  - early post discharge nurse (or pharmacist) phone calls or home visits to confirm understanding of management and follow-up plans in high-risk patients
  - appropriate referral for home care and community support services when needed.

11. Shepperd, S. et al (2013) Discharge planning from hospital to home

Outline: This is a good quality (++) systematic review, which included only RCTs that compared an individualised discharge plan with routine discharge

care that was not tailored to the individual patient. The review reported on a wider range of outcomes than just readmission, but the reviewers focused specifically on this outcome (which was primarily measured as readmission within 3 months as opposed to within 30 days). All studies were quality assessed using the Cochrane 'risk of bias' table and were excluded if they had major methodological weaknesses. Sixteen out of the 24 included studies recruited older patients with a medical condition. The studies were from the USA, UK, Canada, France, Australia, Denmark, the Netherlands and Taipei.

Results

- Unscheduled readmissions to hospital were statistically significantly reduced for elderly patients admitted to hospital with a medical diagnosis and who were allocated to discharge planning (readmission rates RR 0.82, 95% CI 0.73 to 0.92, 12 trials; 3217 participants).
- Evidence suggests that a discharge plan tailored to the individual patient probably brings about reductions in hospital length of stay and readmission rates for older people admitted to hospital with a medical condition.
- One trial, recruiting patients with heart failure, reported a significant improvement on the total score for the Chronic Heart Failure Questionnaire (mean difference 22.1 (20.8); p<0.01) (Rich 1995).
- There is some evidence to suggest that patients receiving discharge planning experience increased levels of satisfaction with their hospital and discharge care (Moher 1992; Weinberger 1996; Laramee 2003); however, overall the impact of discharge planning on mortality, health outcomes and cost remains uncertain.

Studies reporting evidence of cost-effectiveness (n=1)

One UK cost-effectiveness study carried out alongside an RCT was identified (Ellis et al 2006 ++, n=194) which compared a short-term rehabilitation unit with standard community care after hospital discharge for older people. The study found that total mean costs (in 1999/2000 prices) for health and social care were higher in the intervention group at 12 months follow-up (£8,542 vs £8,511); cost of the intervention fell more heavily on social services, while the cost of the comparison group fell more strongly on the NHS. There was no

significant difference in mean survival-at-home time at 12 months (272 days vs 285 days; unadjusted mean diff. 1.28, 85% CI 0.81 to 2.03); however, people in the intervention group were significantly older (p=0.028). Sensitivity analysis showed that standard care was in most scenarios cheaper and missing data had only a modest impact on the results.

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.

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 caregiver) 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 1 of 2 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 2 RCTs that included post-discharge telephone calls and which did not report significant effects. Similarly, 2 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 1 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 (Linertováa 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 1 of 2 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, GPs, 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 RCT (Sadowski 2009 +) found that when housing was offered on discharge from hospital, followed by placement in long-tern 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 1 UK cost-effectiveness evaluation carried out alongside an 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.

Included studies for reducing (30-day) readmissions review questions (full citation)

Allen J, Hutchinson A, Brown R et al (2014) Quality care outcomes following transitional care interventions for older people from hospital to home: a systematic review. BMC Health Services Research 14:1–18

Ellis A, Trappes Lomax T, Fox M, Taylor R, Power M, Stead J, Bainbridge I. (2006), Buying time II: an economic evaluation of a joint NHS/Social Services residential rehabilitation unit for older people on discharge from hospital. Health and Social Care in the Community; 14(2): 95-106

Hansen L, Young R, Hinami K et al (2011) Interventions to reduce 30-day rehospitalization: a systematic review. Annals of Internal Medicine 155: 520–8

Hung WW, Ross JS, Farber J et al (2013) Evaluation of the mobile acute care of the elderly (MACE) service. JAMA Intern Med. 173: 990-996

Jacob L and Poletick E (2008) Systematic review: Predictors of successful transition to community-based care for adults with chronic care needs. Care Management Journals 9: 154–65

Leppin A, Gionfriddo M, Kessler M et al (2014) Preventing 30-Day Hospital Readmissions: A Systematic Review and Meta-analysis of Randomized Trials. JAMA International Medicine 174: 1095–107

Linertová R, Garcia-Perez L, Vazquez-Diaz J et al (2011) Interventions to reduce hospital readmissions in the elderly: in-hospital or home care. A systematic review. Journal of Evaluation in Clinical Practice 17: 1167–75

Naylor M, Aiken L, Kurtzman E et al (2011) The importance of transitional care in achieving health reform. Health Affairs 30: 746–54

Sadowski L, Kee R, VanderWeele T et al (2009) Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: A randomized trial. JAMA: Journal of the American Medical Association 301: 1771–8

Schwarz K, Mion L, Hudock D et al (2008) Telemonitoring of heart failure patients and their caregivers: a pilot randomized controlled trial. Progress in Cardiovascular Nursing 23: 18–26

Scott I (2010) Preventing the rebound: Improving care transition in hospital discharge processes. Australian Health Review 34: 445–51

Shepperd S, Lannin N, Clemson L et al (2013) Discharge planning from hospital to home. Cochrane Database of Systematic Reviews 2013 (1) 1– 91

3.6 Support for carers during transitions

Introduction to the review questions

The purpose of these review questions was to identify approaches to supporting families and carers during transitions between inpatient hospital settings and community or care home settings and to identify evidence about the effectiveness and cost-effectiveness of those approaches. The questions also aimed to consider research which systematically collected the views of people using services, their carers, and care and support staff in relation to approaches and interventions designed to support carers during transitions.

Overall, a moderate amount of evidence about support for carers was located. There was more evidence of views and experiences than there was about the effectiveness of carer support. The views data were mainly of moderate quality and 1 of the studies was from outside the UK because it was judged to be transferable to the UK context and to offer valuable insight. The 2 studies of effectiveness and 2 of the views and experiences studies related to support for carers of stroke patients. A task for the Guideline Committee was to

consider the generalisability of findings to the wider population of carers for adults with social care needs during transition to and from hospital.

Review questions for evidence of effectiveness

11 (a) 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?

11 (b) How should services work with families and unpaid carers of adults with social care needs during transition between inpatient hospital settings to community or care home settings?

Review questions for evidence of views and experiences

Review questions 1–4 and question 10, listed on pages 2–3, were applied specifically in relation to carer support during transitions.

Summary of review protocol

The protocol sought to identify studies that would:

- draw on material identified in questions 1, 5, 6, 7, 8 and 9 to identify approaches in care planning and delivery which enable carers, partners and families to participate in care planning and delivery during transitions between in inpatient hospital settings and community or care home settings
- identify and evaluate interventions and approaches (including information and education) which support carers in the tasks of caring during transitions
- consider how providers of social care and healthcare should work in partnership and support families and unpaid carers of adults with social care needs during admission to and discharge from hospital.

For the views and experiences review questions, the protocol sought to identify studies specifically relating to carer support that would:

- describe the self-reported views and experiences of adults with social care needs, their families and unpaid carers about the support carers receive during transitions between hospital and home

- highlight aspects of support for carers during the hospital admission and discharge process that work well, as perceived by service users, their families and unpaid carers and aspects of care and support for carers which are perceived not to work well.

- describe the views and experiences of people delivering, organising and commissioning social care, health and housing services in relation to carer support

- highlight aspects of carer support which work well and are personalised and integrated, as perceived by practitioners, managers and commissioners, and aspects which should be changed

- contextualise the views of users, carers and practitioners by identifying barriers and facilitators to improved or changed practice they suggest would improve the outcomes of carer support.

Population: Families, partners and unpaid carers of adults with social care needs during a transfer of care from inpatient hospital settings to community or care home settings and during admission to inpatient hospital settings from community or care home settings. Families, partners and unpaid carers of self-funders experiencing a transfer of care from inpatient hospital settings to community or care home settings and vice versa are included.

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

Intervention: 'Support to care' (involvement in planning and delivery, specific support such as needs assessment and respite, training in skills such as lifting; support to enable social participation and reduce isolation of carers).

Setting: Inpatient hospital settings, hospices, bed-based intermediate care settings ('step down' and 'step up') and service users' home, including

sheltered housing accommodation; supported housing; temporary accommodation; care (residential and nursing) homes.

Outcomes: Carer outcomes (such as carer satisfaction; quality and continuity of care; quality of life, perception of carer burden; choice and control for users and carers; involvement in decision-making; dignity and independence; health status of carer; safety and safeguarding. Service outcomes including hospital readmissions, avoidable admissions, length of stay in hospital.

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

The study designs included for the effectiveness questions on reducing hospital readmissions were:

- systematic reviews of qualitative studies on this topic
- systematic reviews utilising measures of carer burden and satisfaction
- RCTs and cluster-randomised trials of interventions to support carers to care (for example, education)
- controlled studies of interventions to support carers to care (for example, education)
- economic evaluations.

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

- systematic reviews of qualitative studies on this topic
- qualitative studies of user and carer views of carer support
- qualitative components of effectiveness and mixed methods studies
- observational and cross-sectional survey studies of carer and user experience.

Full protocols can be found in Appendix A.

How the literature was searched

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

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

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

Searches were also rerun in June 2015 and a summary of the studies for this review area can be found in section 3.8.6.

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

How studies were selected

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

- language (must be in English)

- population (must be over 18 years of age and have a social care need)
- transition (a transition into or out of an inpatient hospital setting must have occurred within the last 30 days)
- intervention (must be involved in supporting transitions)
- setting (inpatient hospital setting, intermediate care setting, community setting or care home)
- country (must be UK, European Union, Denmark, Norway, Sweden, Canada, USA, Australia or New Zealand)
- date (not published before 2003)
- type of evidence (must be research)
- relevance to (one or more) review questions.

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

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

In our initial screen (on title and abstract), we found 51 studies which appeared relevant to the review questions on support for carers during transitions. We ordered full texts and reviewed 27 papers for final inclusion. For views and experiences research, studies from a UK setting were prioritised. Effectiveness studies were restricted to systematic reviews, RCTs or controlled studies. On reviewing the full texts, we identified 7 which fulfilled the criteria (see included studies below) plus 2 economics studies. The included studies (see below) were critically appraised using NICE tools for appraising different study types, and the results tabulated. Further information on critical appraisal is given in the introduction at the beginning of Section 3. Study findings were extracted into findings tables. For full critical appraisal and findings tables, see Appendix B.

Narrative summaries of the included evidence

Studies reporting effectiveness data (n=3)

1. Bakas, T., Farran, C., Austin, J., Given, B., Johnson, E. and Williams L. (2009a) Stroke caregiver outcomes from the Telephone Assessment and Skill-Building Kit (TASK)

Outline: This is a good quality (++) mixed methods study, which is highly relevant to the review question. The study comprised of a literature review and evaluation of the Telephone Assessment and Skill-building Kit (TASK), which is an 8-week programme that addresses caregiver needs. The TASK intervention comprised of written tip sheets addressing each of the 32 items in the Caregiver Needs and Concerns Checklist (CNCC) in 5 areas of skill-building needs:

- finding out information about stroke
- managing survivor's emotions and behaviours
- providing physical care
- providing instrumental care
- dealing with personal responses to providing care.

In addition, a workbook and five process tip sheets provided skill-building strategies on strengthening existing skills, screening for depressive symptoms, maintaining realistic expectations, problem-solving and communicating with health professionals. The tip sheets and workbook were developed and revised based on input from 10 experts (see Bakas 2009b under 'views and experiences data').

Results: Based on findings from the literature review authors conclude that skill-building is more helpful to care givers than psychoeducational support, that caregivers find managing emotions and behaviours of stroke survivors among the most stressful part of providing care and that caregivers often neglect their own physical and mental health needs.

The evaluation found increases in measures of optimism at 4 weeks, 8 weeks and 12 weeks with a medium effect size for the TASK group compared to the

attention control group. Significant improvements were also reported for the task difficulty situational factor at 4 weeks, and threat appraisal at both 8 weeks and 12 weeks.

There were no significant differences found between groups on measures of health perceptions, depressive symptoms, and caregiver life changes at 4, 8 or 12 weeks.

2. Forster, A. et al (2013) A cluster randomised controlled trial and economic evaluation of a structured training programme for caregivers of inpatients after stroke: the TRACS trial

Outline: The Training Caregivers After Stroke (TRACS) trial was a good quality (++/++), relevant, pragmatic, multi-site clustered RCT conducted in the UK. The trial collaboration team followed up the smaller RCT (Kalra et al 2004) London Stroke Carer Training Course (LSCTC – narrative summary, below), a standardised structured competencies-based training programme, to test the effectiveness, acceptability and feasibility of scaling up the TRACS programme as standard practice for all caregivers of stroke survivors.

The London Stroke Carer Training Course (LSCTC) programme consisted of 14 core competencies designed to train and test the skills and knowledge needed to care for a stroke patient at home. The programme was modified to allow the intervention to be implemented in multiple NHS settings by stroke rehabilitation units and multidisciplinary teams with a range of skills and expertise.

Results: Unlike the Kalra RCT, the research team did not identify significant differences between the two groups on any of the following measures at 6 or 12 months follow-up:

- Nottingham Extended Activities of Daily Living (NEADL) scale
- Activities of Daily Living (ADL) Barthel Index
- Hospital Anxiety and Depression Scale (HADS)
- health state (EQ-5D)
- Stroke Impact Scale (SIS) physical domain

- Caregiver Burden Scale.

These results are at odds with the Kalra findings but the following possible reasons for the different results should be considered:

- In the 9 years since the Kalra RCT LSCTC, standard care may have improved to be at least as good as that offered by the TRACS programme.
- The impact of the programme was beneficial for some people and detrimental for others. This could lead to a no difference result. The indication here would be the programme may be better targeted to some groups of caregivers rather than offered as standard practice for all caregivers of stroke survivors.
- There were differences in the implementation of the programme between the two studies. The smaller Kalra study may have benefited from higher practitioner engagement, and the same staff responsible for the delivery in a single site compared to the routine delivery of the programme across multiple sites. This could mean that the programme would be difficult to scale up in multi sites as standard practice.

3. Kalra, L., Evans, A., Perez, I., Melbourn, A., Patel, A., Knapp, M. and Donaldson, N. (2004) Training care givers of stroke patients: randomised controlled trial

Outline: This is a good quality (++) single blind RCT, which is highly relevant to the review area. The study aimed to evaluate the effectiveness of caregiver training in reducing burden of stroke in patients and their caregivers. Out of 300 carer/patient dyads, 151 dyads were randomised to receive caregiver training. The intervention included: instruction on prevention and management of common stroke-related problems – including continence, nutrition and gait facilitation; advice on benefits and local services; 'hands on' training in lifting and handling techniques; assistance with personal ADL tailored to the needs of individual patient; and a 'follow through' session upon return home. Robust, well validated and objective outcomes were used to measure caregiver and patient function, depression, mortality, caregiver burden and costs at 3 and 12 months.

Results

- Training caregivers during patients' rehabilitation reduced costs and caregiver burden while improving psychosocial outcomes in caregivers and patients at 1 year.

- There were no significant differences in patient mortality, institutionalisation or functional abilities between the training and control group.

- Patients whose caregivers had received training reported significantly improved quality of life and mood outcomes, both at 3 and 12 months.

- Burden of care was reduced significantly and quality of life and mood in care givers improved significantly at 3 and 12 months.

- Caregiver training was associated with significant cost reductions over 1 year (£10,133 (SD £8676) vs £13,794 (SD £10,510); p=0.001), mainly because of lower hospital costs (£8,987 (SD £7,368) vs £12,383 (SD £9,104)).

Studies reporting views and experiences data (n=4)

1. Addington-Hall, J. and Armes, P. (2003) Perspectives on symptom control in patients receiving community palliative care

Outline: This qualitative case study of moderate quality (+) was carried out in a specialist palliative care service (SPCS) in South London which provides both inpatient and home care services. The study aimed to explore the reasons why patients required crisis management and were admitted for inpatient care. The paper mainly focused on carers' ability to manage and interpret their relatives' symptoms in the home, with a view to avoiding admissions (which is out of scope) rather than ensuring successful admissions. As the study presents findings on how service providers can work in partnership with family caregivers who were caring for someone admitted into inpatient care the study has been included for this review area, but on account of the admission avoidance bias the external validity has been graded as low (-).

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

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

Knowing what to monitor, how to interpret the signs and when to inform a health professional were all issues of concern for carers as they recognised that these were important for the achievement of symptom control.

Carers explained that they were not always kept informed in the way that they wanted to be. For example, one carer, who wanted to be with their relative when they were dying, was not informed that their death was imminent.

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

Could improve admission

More information and education (on symptom management) needs to be given to carers to allow them to fulfil their roles more successfully. Monitoring a symptom not only requires that carers are aware of what to report but also that they are able to decide when to report it.

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

When health professionals were not provided with accurate and reliable information this often resulted in crisis management (ie the patient was admitted to inpatient care).

A number of times health professionals felt that certain symptoms should have been reported earlier so that they could intervene before the situation became unmanageable.

2. Bakas T., Farran, C.J, Austin, J.K., Given, B.A., Johnson, E.A. and Williams, L.S. (2009b) Content validity and satisfaction with a stroke caregiver intervention program

Outline: This was a mixed methods study of moderate quality (+) and high relevance (++) that included both views of carers and measures of impact. Stroke caregivers often express the need for information about stroke and assistance with stroke-related care in the early discharge period. The Telephone Assessment and Skill- Building Kit (TASK) is an 8-week programme that addresses caregiver needs. The underlying conceptual model was derived from Lazarus's transactional theory of stress, which is outlined in the narrative summary for Bakas et al (2009a) (above). This and Bakas et al are linked papers.

The element of the evaluation reported in this paper is the development of the TASK intervention tip sheet and workbook, for which experts were employed to rate the TASK intervention components for accuracy, feasibility, acceptability and problem relevance. A convenience sample of 40 stroke caregivers also rated the intervention for usefulness, ease of use and acceptability. The qualitative component is limited to selected quotes that illustrate survey response findings. The survey responses and the qualitative components inform the data extraction for this paper.

Results: The stroke survivor's caregiver intervention group scored higher than the control group on all satisfaction domains (usefulness, acceptability and overall satisfaction) with a large effect size of 0.81.

Most of the non-significant effects were about the usefulness, ease of use and acceptability of the nurse's phone calls: 'the calls from the nurse helped me', 'The nurse calls each week were convenient' and 'I like getting calls from the nurse' (p372).

In addition, a non-significant effect was found in the usefulness domain on the statement: 'The TASK/ ASA pamphlet tip sheets work well for me'.

The non-significant effect of the 'The TASK/ASA pamphlet tip sheets work well for me' sub-scale may be due to a lack of ability to make a comparison

between the two types of approaches and pick a preference, or that most (if not all) caregivers would find information provided after discharge useful to some degree.

The findings from the satisfaction survey were supported by selected quotes from both the intervention and the control group that contact with nurses after discharge was highly valued and may explain the non-significant differences between the groups on the questions that related to the nurse contact.

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

Proactive support: It is likely that caregivers of stroke survivors had no previous experience of this event or anything comparable to it, they did not know what to expect and appreciated the proactive approach of being invited to take part in the intervention: 'I'd never been in this situation before and I had absolutely no clue of what to do or how to go about anything, so I think the information that you provided was just what I needed' (p372).

3. Cobley, C.S., Fisher, R.J., Chouliara, N., Kerr, M. and Walker, M.F. (2013) A qualitative study exploring patients' and carers' experiences of early supported discharge
Outline: This is a good quality (++) views study that aimed to fill the gap in patient and carer perceptions of early supported discharge (for stroke patients) during the early post-discharge phase in the UK. It was intended to inform future early supported discharge service development and provision. The study employed a constant comparative method to develop themes from interviews given by participants receiving early supported discharge as well as people who did not. Common themes across both groups were identified plus themes that were only reported by individuals who received early supported discharge.

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

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

Works well

Respite time for the carer emerged as a significant and recurring theme. Carers reported that the therapeutic sessions between the patient and the early supported discharge team enabled them to engage in their own activities: 'I could get on with the little jobs that wanted doing, or I could just put my feet up and have a rest, so it made life a darn sight easier for me' (p753).

Could be improved

Provision and delivery of information: 'I thought it'd be good to talk about if you were entitled to any benefits because I've never been on the sick ever. I didn't understand any of it, we had to figure it out for ourselves' (p755).

'It would have been nice to have somebody sit down with me and say this is what's happened, this is why it's happened, this is what you can expect. Okay, so it is there in the leaflets but you just kind of flick through the leaflets' (p755).

Limited support in dealing with carer strain: some carers felt that there was little support or recognition of carer strain and the strain on physical and mental health as well as a strain on family and social relationships. Carers also described their difficulties in dealing with emotional and psychological needs, both for themselves and for the person they were caring for: 'His depression ... I just don't know what to do. I can't cope because I don't know what to do to stop it' (p754).

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

What helps

Satisfaction with provision and delivery of equipment: there was a general consensus that the equipment provided was useful and delivered in a timely manner.

What makes it difficult

Provision and delivery of information

Some participants expressed their concerns about their limited understanding of stroke and its causes, secondary preventative measures and lifestyle changes. Some caregivers felt that information wasn't provided in the right format: 'I wouldn't have a clue what was normal, what wasn't normal ... who to ask for help and advice. I mean the internet's okay, but it only takes it so far. Sometimes you need a person to put it into terms that you understand. Because it's stressful when you don't know what's going on' (p754).

Disjointed transition between early supported discharge and future services

Some patients felt that the 6-week cut off from early supported discharge was 'abrupt' and not 'continuous enough'.

Lack of education and training of carers

Some respondents felt that they were thrown into the caring role without receiving enough support from the community stroke teams: 'I don't think they told me anything. I was just left out in the cold ... I didn't have a clue what was going on' and 'I wasn't shown the best way to support him ... it was all trial and error' (p754).

4. Pearson, P., Procter, S., Wilcockson, J. and Allgar, V. (2004) The process of hospital discharge for medical patients: a model

Outline: This moderate quality (+) paper reports on the qualitative findings of a study which tracks decision-making processes surrounding hospital

discharge. The study considers outcomes for a sample of medical patients and their carers who were identified as being at risk of experiencing unsuccessful discharge processes. The authors define unsuccessful discharge as: 'unplanned readmission within 6 months of discharge, or delayed discharge'. Evidently, the paper overlaps with the 'discharge planning' and 'avoiding 30-day-readmission' review areas, and has been graded as being 'somewhat relevant' to the current review area, 'support for carers during transition from inpatient hospital settings to community or care home settings'.

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

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

Loss of identity, or fear of its loss, was an issue for 14 patients (out of 30), and 10 commented that their illness prevented them from fulfilling previous roles.

For many patients the opportunity to sustain their previous values and identity while maintaining an appropriate social role was an important component of their ability to manage their health problem(s) successfully.

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

Carers perceived themselves as forming a 'barrier' when healthcare practitioners were assessing patients' needs: if they were 'there', then they could cope. Carers were taken for granted and assumptions were made that they would take on support of patients after discharge (regardless of capacity).

Carers described the process of juggling their own needs, their family's needs and those of the patient. They experienced constant pressure to prioritise,

seeking to find a balance between different demands and drawing on what resources they could find.

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

Could improve the transition

More information and consistent behaviour from health and social care professionals. Carers said that a lack of information and the perceived contradictory behaviour of professionals exacerbated their anxiety as caregivers.

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

Nurses described preparation for discharge mainly in terms of ordering drugs and arranging transport. GPs described 'picking up the pieces' following discharge.

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

What could be improved?

Some nurses indicated that they were unable to achieve an adequate level of understanding of each patient and their individual circumstances because they were short staffed. Only 4 nurses mentioned some consideration of the patient's home circumstances and 7 spoke of giving information to relatives.

GPs received inadequate discharge notes from the hospital, which led to problems providing continuity of care for patients in the community.

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

What helps

The findings from this study reinforce the need for active involvement of patients and carers in discharge planning.

Makes it difficult

Carers highlighted the inadequacy of the environment in which patients were expected to recuperate after hospitalisation – a setting which they saw as purposeful, compared with the isolation of the environment to which they were discharged.

Studies reporting evidence of cost-effectiveness (n=2)

One UK cost-utility study that was carried out alongside an RCT was identified (Patel et al 2004 ++, n=300). The intervention referred to 3 to 5 training sessions for carers (30–40 mins) 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 (Forster et al 2013 ++ 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 2 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.

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 hospitalisation 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, while 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 1 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. While 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). The 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.

Included studies for the support for carers review questions (full citation)

Addington-Hall J and Armes P (2003) Perspectives on symptom control in patients receiving community palliative care. Palliative Medicine 17: 608–15

Bakas T, Farran C, Austin J et al (2009a) Stroke Caregiver Outcomes from the Telephone Assessment and Skill-Building Kit (TASK). Top Stroke Rehabilitation 2: 105–21

Bakas T, Farran C, Austin J et al (2009b) Content Validity and Satisfaction with a Stroke Caregiver Intervention Program. Journal of Nursing Scholarship 41: 368–75

Cobley, C., Fisher, R., Chouliara, N et al (2012) ESD Services: Patient and carer experiences and perspectives. Clinical rehabilitation 27: 750–7

Forster, A., Dickerson, J., Young, J., Patel, A., Kalra, L., Nixon, J., Smithard, Knapp, M., Holloway, I., Anwar, S. and Farrin, A (2013) TRACS Trial Collaboration; A cluster randomised controlled trial and economic evaluation of a structured training programme for caregivers of inpatients after stroke: the TRACS trial. Health technology assessment 17: 1-216

Kalra L, Evans A, Perez I et al (2004) Training care givers of stroke patients: Randomised controlled trial. British Medical Journal 328: 1099–101

Patel A, Knapp M, Evans A, Perez I, Kalra L (2004), Training care givers of stroke patients: economic evaluation, British Medical Journal, 328:1-6.

Pearson P, Procter S, Wilcockson J et al (2004) The process of hospital discharge for medical patients: a model. Journal of Advanced Nursing 46: 496–505

3.7 Practitioner training to support transitions

Introduction to the review questions

The purpose of these review questions was to examine the impact of training to support transitions between inpatient hospital settings and community or care home settings. The aim was to examine the effectiveness of training in terms of the impact on practitioners as well as on the outcomes of transitions at the individual and service levels. The questions also aimed to consider research which systematically collected the views of care and support staff and people using services and their carers in relation to training and continual professional development for improving transitions between hospital and home.

Overall, a small amount of evidence about training to support transitions was located and reviewed. There was no evidence 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. The studies all evaluated training for medical (and pharmacy) students so a task for the Guideline Committee was to consider the generalisability of findings to the wider population of care and support staff involved in transitions.

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.

The impact studies all evaluated training for medical (and pharmacy students). Consider applicability to other professional groups.

Review question for evidence of effectiveness

12. What is the impact of training to support transitions between inpatient hospital settings and community or care home settings?

Review questions for evidence of views and experiences

Review questions 1–4 and question 10, listed on pages 2–3, were applied specifically in relation to practitioner training to support transitions.

Summary of review protocol

The protocol sought to identify studies that would:

- identify the effectiveness of approaches to existing induction, training and continuing personal development delivered to social care staff, (unregulated) personal assistants and hospital staff involved in admission and discharge processes
- identify the potential for improvement in this area
- identify possible barriers and facilitators to the implementation of training and support for social care and relevant hospital staff to improve transitions between health and social care
- consider whether and how increased integration could foster shared learning with healthcare staff in relation to improving transitions between inpatient hospital settings and community or care home settings.

For the views and experiences review questions, the protocol sought to identify studies specifically relating to practitioner training that would:

- describe the self-reported views and experiences of adults with social care needs, their families and unpaid carers about the training that practitioners receive to improve transitions between hospital and home
- highlight aspects of training for practitioners that work well, as perceived by service users, their families and unpaid carers and aspects of training which are perceived not to work well
- describe the views and experiences of people delivering, organising and commissioning social care, health and housing services in relation to training to support transitions
- highlight aspects of practitioner training which work well, as perceived by practitioners, managers and commissioners and aspects which should be changed
- contextualise the views of users, carers and practitioners by identifying barriers and facilitators to improved or changed training that they suggest would improve the outcomes of transitions.

Population: Social care practitioners (providers, workers including home care workers, managers, social workers), and social care commissioners involved in delivering social care to people during transition between inpatient hospital settings and community or care home settings or intermediate care units; (un-regulated) personal assistants engaged by people with social care needs and their families (including self-funders).

General practice and other community-based healthcare practitioners: GPs and community/district nurses – nurses in residential care settings, physiotherapists and other therapeutic professionals; hospital ward staff (with a role in hospital admission and discharge procedures).

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

Intervention: Organisational skills support; models of integration and cross-agency work and training; personalised services which respond to the needs of the individual, and to identify and respond to existing or evolving problem conditions. Staff support, supervision, training and assessment. Development and use of protocols.

Setting: Inpatient hospital settings, bed-based intermediate care settings ('step down' and 'step up') and service users' home, including sheltered housing accommodation; supported housing; temporary accommodation; care (residential and nursing) homes.

Outcomes: Effectiveness studies of 'training' with follow-up; outcomes relating to safeguarding and safety, such as falls prevention; reduction in hospital bed days, reduction in hospital readmissions: implementation of CQC regulations and contract monitoring.

Practitioner satisfaction, knowledge and skills. User and carer satisfaction; quality and continuity of care; choice and control; involvement in decision-

making; dignity and independence; quality of life; health status; safety and safeguarding.

The study designs included for the effectiveness questions on reducing hospital readmissions were:

- systematic reviews of quantitative studies on relevant interventions
- standardised scales measuring satisfaction and wellbeing
- RCTs and cluster RCTs on training
- controlled studies and on training
- pre-test, post-test evaluations
- economic evaluations.

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

- systematic reviews of qualitative studies on relevant interventions
- qualitative studies of service user and carer views of training and competencies of staff (drawing on questions 1 and 2)
- qualitative studies of practitioner views of training and competencies of staff
- qualitative components of effectiveness and mixed methods studies
- observational and cross-sectional survey studies of carer and user experience.

Full protocols can be found in Appendix A.

How the literature was searched

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

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

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

Searches were also rerun in June 2015 and a summary of the studies for this review area can be found in Section 3.8.7.

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

How studies were selected

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

- language (must be in English)
- population (must be over 18 years of age and have a social care need)
- transition
- intervention (must be involved in supporting transitions)
- setting (inpatient hospital setting, intermediate care setting, community setting or care home)
- country (must be UK, European Union, Denmark, Norway, Sweden, Canada, USA, Australia or New Zealand)

- date (not published before 2003)
- type of evidence (must be research)
- relevance to (one 1 or more) review questions.

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

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

In our initial screen (on title and abstract), we found 21 studies, which appeared relevant to the review questions on training for practitioners. We ordered full texts of 17 papers, which appeared to apply to a UK setting (for views and experiences studies) or, for effectiveness studies, met the criteria of being systematic reviews, RCTs, controlled studies or pre-test, post-test evaluations. On reviewing the full texts, we identified 4 which fulfilled these criteria, although the views study was not from the UK (see included studies below). No relevant economic studies were located. The included studies were critically appraised using NICE tools for appraising different study types, and the results tabulated. Further information on critical appraisal is given in the introduction at the beginning of Section 3. Study findings were extracted into findings tables. For full critical appraisal and findings tables, see Appendix B.

Narrative summaries of the included evidence

Studies reporting effectiveness data (n=3)

1. Eskildsen, M., Chakkalakal, R. and Flacker, J. (2012) Use of a virtual classroom in training fourth-year medical students on care transitions

Outline: This is a moderate quality (+) survey, which evaluated the effectiveness of a new care transitions curriculum taught to all fourth-year medical students at Emory University School of Medicine. The course consisted of 3 components: a presentation on care transitions with an associated case discussion; training on discharge summaries; and the execution of a post-discharge phone call.

Questionnaires were used to measure changes in medical students' pre-test to post-test confidence in performing discharge tasks, attitudes toward the care transitions process and performance on a knowledge quiz. Students' satisfaction with the course was also assessed, as was the quality of the students' discharge summaries and post-discharge call reports performed during the module. Discharge summaries were deemed 'satisfactory' if they had the 5 following components:

- a documented discharge medication list with specific dosing schedules

- lists of admission medications and/or a list of medication changes during hospitalisation
- a discharge plan that specifies the next setting of care, as well as the planned follow-up
- a hospital course organised by system and/or specific chronology
- a physical exam, laboratory tests and diagnostic studies performed on admission.

'Satisfactory' post-discharge phone calls had to contain at least the following 2 elements:

- a discussion of the patient's medication list, including documentation of a discussion of hazardous medications (for example, furosemide, warfarin, digoxin, insulin) if applicable

- documentation of a discussion on follow-up plans with a primary physician or specialist.

The authors credit Dr Karin Ouchida of Montefiore Medical Centre for help with developing questionnaire items, and reference Lai et al (2008), from which the 5 multiple-choice questions measuring students' confidence were developed. Both Lai (2008) and Ouchida (2009) are reviewed as separate (unlinked) studies under this review question.

Results

- Students' confidence in their ability to perform discharge tasks improved from 16.7 to 20.7 on a 25-point scale ($p<0.001$).

- The change in students' attitudes regarding the importance of different components of the care transitions process was not statistically significant ($p=0.07$).

- Changes in total knowledge scores were statistically significant: the mean percentage of correct answers out of 10 rose from 68% on the pre-test to 82% on the post-test ($p<0.001$).

- 90.1% (109/121) of discharge summaries and 90.1% (109/121) of post-discharge call reports performed during the module met all quality criteria.

2. Lai, C., Nye, H., Bookwalter, T., Kwan, A. and Hauer, K (2008) Post-discharge follow-up visits for medical and pharmacy students on an inpatient medicine clerkship

Outline: This is a moderate quality (+) study, which was designed to determine whether a discharge curriculum would improve students' attitudes and self-assessed skills in interdisciplinary collaboration and transitional care for chronically ill patients. The discharge curriculum comprised of an

interdisciplinary workshop, follow-up visits with discharged patients, a final group debriefing and letters to patients' primary care providers. The effects of the curriculum were tested via a before and after 5-point Likert-scaled survey to establish the change in students' attitudes and skills in interdisciplinary collaboration. Students reported their satisfaction using additional Likert-scaled and open-ended questions. The survey methods were judged to be appropriate to the aims of the study.

Results

Student rated satisfaction with the curriculum

Overall programme

Mean score (scale 1–5): 4.1: SD 1.14: 86% rated the curriculum very good or excellent.

Most valuable components

- The interdisciplinary collaboration on patient care (4.5: SD 1.04: 94%).
- The post discharge visit (4.3: SD 0.68: 91%).
- Followed by the debriefing session (3.9: SD 1.04: 74%).

Least useful components

- The initial workshop on interdisciplinary roles (3.6: SD 1.18: 54%.
- The write-up to the primary care provider (3.4: SD 0.81: 48%).

Student assessment of impact of discharge curriculum

- 91% of students agreed that they learned skills valuable for future patient care (medical students 4.4, SD 0.61; pharmacy students 4.1, SD 0.62).
- Most students agreed that the programme enhanced their learning about interdisciplinary care (4.3, SD 0.72), discharge planning (4.4, SD 0.70), and humanism (4.4 SD 0.63).
- 93% agreed that the curriculum was valuable to their education.

Some views and experiences data were also reported in this paper and presented below under the relevant review questions:

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

Works well

Students felt the most valuable component of the curriculum was seeing patients at home in their social context (30 total comments): 'I was unaware of the types of living conditions many patients face, especially in the setting of chronic disease. In the future I will try to gain a more detailed understanding of my patients' social situations in order to help identify and anticipate problems in the management of their medical issues' (p23).

Thirteen students valued the interdisciplinary team working, which was a feature of the curriculum.

Eight students said they appreciated learning about transitional care and the components of discharge planning. The following quote reflects on managing medication during the transition process with the student describing how this could be done better in future: 'I was a little surprised during this home visit to find how much Ms C had altered her medication regimen. She didn't like how she was feeling on the higher blood pressure medications, so she halved them. She doesn't really like taking pills, in general, so she stopped taking the aspirin, Senna, and Colace. I suppose something that might have made this discharge more successful would have been if we had really elicited her preferences regarding medications while she was in the hospital, such that we could have been more selective in what we prescribed and very clear with her with respect to what exactly we were hoping to accomplish with each' (p23).

Other students described how the curriculum helped them to recognise that patients lack understanding about medication regimens after transfer home. In this context, they discussed the importance of communicating with patients' primary care providers about the hospital course and follow-up.

3. Ouchida, K., LoFaso, V., Capello, C., Ramsaroop, S. and Reid, M. (2009) Fast forward rounds: an effective method for teaching medical students to transition patients safely across care settings

Outline: This is a moderate quality (+) study with moderate relevance to the review area. Authors test two hypotheses about improving knowledge and practice in relation to transitions from hospital to home:

Hypothesis 1. That a curriculum combining an interdisciplinary team approach and diverse teaching modalities would improve participants' transitional care knowledge, perceived competence in managing the discharge process and frequency of transitional care behaviours such as patient education and medication reconciliation. Hypothesis 2. That participants would respond positively to an interactive, multimodal learning climate.

The authors discuss the problems associated with transitions including care falling between staff responsibilities and increased numbers of care providers sharing the care of a given patient. They argue that this has been compounded because there has been no concurrent increase in training nor incentives to collaborate across settings.

The development of the Fast Forward Round training curriculum formed part of a mandatory component of the 12-week internal medicine clerkship. The programme involved 2 90-minute sessions that incorporated interdisciplinary lectures, and educational digital video, small group discussions and team-based learning exercises. The programme was attended by 103 third- year medical students. Increases in knowledge were assessed via a 28 item assessment tool in the domains of transitional care, functional assessment, interdisciplinary team, community resources, and reimbursement. The post-test questionnaire also elicited feedback via open- ended questions about the course, the overall effectiveness and the effect of the course on patient care.

Results: Significant positive percentage gains were observed pre-test to post test on all domains, but the greater gains were seen in the domains of functional assessment, interdisciplinary team and transitional care.

Within the transitional care domain, significant gains were observed for knowledge, attitudes and behaviour:

- The proportion of students who can correctly identify medication errors as being the most common source of adverse events after hospital discharge increased from 14.9% to 56%, P<.001.
- Confidence levels in managing the discharge process for patients with a chronic illness increased from 9.8% of participants feeling competent or expert before the teaching to 66.3% of participants feeling competent or expert afterwards, P<.001
- Feeling skilled in educating patients and carers about discharge medications increased from 28.4% of participants to 75.8% of participants, P<.001
- Demonstrating an increase in key transitional care behaviours, such as reporting that they now reviewed discharge medications with patients and caregivers: 42.3% to 50% , P<.002,
- The growth in the number of students performing medicines reconciliation was not significant but showed a positive direction of effect.

Some views and experiences data were also reported in this paper and presented below under the relevant review question:

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

Works well

Participating students described the positive change in awareness and change in the level of importance attributed to discharge planning for successful transition, ''[The course] reminded me [of] the importance of discharge summaries when so often they are considered formalities" (p915)

Students also became more aware of services in the community that could integrate with care from hospital to home, "I am more aware of the services that exist for patients once they leave the hospital.'' And ''I will be better able

to think about my patients' post-discharge care and know what to do to help them at home." (p915)

Participants also reported a feeling of knowing the patient and their needs in a more holistic way and how this might translate to discharge planning practice in the future, "[The course] made me think about what the patient's life is like when they leave so as to make it easier and prevent re-admission." And "[I have a] desire to be more personal with the patient and really emphasize patient education to improve compliance." (p914)

"[The course] helped me with understanding the patient's perspective from discharge and realize how little they know. I take more time now in explaining to patients what is going on, tell them test results, etc." And "I will spend more time explaining the discharge plan to patients." (p915)

Participants reported that the changes in knowledge and attitudes may also have enabled them challenge the prevailing culture of resistance to prioritising the discharge process, described by the authors as the "hidden curriculum".

Could be improved

Feedback from the students indicated that the course was so helpful that they would have preferred for the training to be made available earlier on in their programme to enable them to put their new knowledge into practice.

Studies reporting views and experiences data (n=1)

1. Northrup-Snyder, K., van Son, C. and McDaniel, C. (2011) Thinking beyond "the wheelchair to the car": RN-to-BSN student understanding of community and public health nursing

Outline: This was a low quality [-] study, judged to be of little relevance to the UK context. Authors employed methods of retrospective content analysis of online comments made by registered nurses (RNs) taking a community health course as part of their bachelor of science in nursing degree programme (BSN). The Authors point to a gap in training from the level of registered nurse to BSN. They hypothesise that the additional training for community health nursing that forms part of the training in the bachelor degree programme

would lead to an increase in knowledge and improvement in attitudes towards community health nurse roles and practice. The authors suggest that ultimately, this would enable the acute care nurse to facilitate a smoother transition for patients returning home.

Results: Understanding: Home–Hospital–Home Patient Transitions.

Context of Care

Nurse's comments reflected changing attitudes towards the boundaries of care extended beyond the hospital to the community:

"I will think beyond "from the wheelchair to the car" as I discharge patients. I will...have the big picture of the client's home environment, neighbourhood, state, nation and world" (p228)

"While assessing, [I'm] always thinking about the community they live in and how that affects their health, [and this] will be taken into consideration. Discharge planning will be looked at dramatically different due [to] my experiences in this course". (p228)

Nurses' comments also suggested that they became more aware of the challenges that these necessary links across settings and staff might create:

"I think discharge planners are a link between the entities. But, as an acute care nurse, or as a community nurse, how could you create a line of communication with each other?" (p228)

Patient-Centred Approach.

A theme that emerged from the online comments was the challenge of how to apply patient-centred care to their acute care practice, "I really envied them [the public and community health nurses] their ability to really know, see, and care for the patient." (p228)

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. One survey (Eskildsen et al 2012 +) found that when medical students followed a care transitions curriculum, 90% 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 benefited 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.

Included studies for the training review questions (full citation)

Eskildsen M, Chakkalakal R, Flacker J et al (2012) Use of a virtual classroom in training fourth-year medical students on care transitions. Journal of Hospital Medicine 7: 14–21

Lai C, Nye H, Bookwalter T et al (2008) Post-discharge follow-up visits for medical and pharmacy students on an inpatient medicine clerkship. Journal of hospital medicine: an official publication of the Society of Hospital Medicine 3: 20–27

Ouchida K, LoFaso V, Capello C et al (2009) Fast forward rounds: An effective method for teaching medical students to transition patients safely across care settings. Journal of the American Geriatrics Society 57: 910–17

Northrup-Snyder K, van Son C, McDaniel, C (2011) Thinking beyond 'the wheelchair to the car': RN-to-BSN student understanding of community and public health nursing. Journal of Nursing Education 50: 226–9

3.8 Summary from re-run searches

An updated search was carried out in June 2015 to identify experimental design and views studies published since the original searches were conducted for this guideline. The 3559 search outputs were screened for inclusion and relevance to the review question areas, according to the original review protocols. A total of 43 studies were identified as having met the inclusion criteria and potentially offering new material. The title and abstract of each included paper was reviewed to ascertain:

- whether the study findings contradicted or reinforced existing guideline recommendations (and if so, which recommendations were involved)

- whether recommendations should be amended, or new recommendations added, in light of the new evidence.

To summarise, most of the new research papers supported the existing draft recommendations. In a small number of cases, the research papers did not clearly relate to the draft recommendations. However, the stated study limitations indicate they would not have provided evidence on which to base new recommendations. In conclusion, on the basis of this title and abstract review, no further action is recommended.

Analyses of the new studies and relevant recommendations are presented by review area.

3.8.1 Review area: transition between inpatient hospital settings and community or care home settings for people with mental health difficulties

On the basis of title and abstract review, 1 additional study (Peel et al 2015) was included under this review area. It is a prospective cohort study providing evidence of effectiveness.

Summary of evidence based on title and abstract

The new study, conducted in Australia, evaluates the impact of transitional care programmes (TCPs) on people with different levels of cognition. TCPs provide a combination of health and social care services and therapy to support older people at the end of their hospital stay. The objective is to facilitate discharge from hospital and give people more time to recover and support to regain independence. Transitional care is provided either in people's own homes or via a short-term placement in a residential setting.

The study, using a controlled, prospective cohort design, aimed to evaluate the impact of TCP on patients according to their cognitive status. The abstract does not provide a lot of information apart from the methods and the results, which showed no significant difference in TCP outcomes between two groups, one assessed as being cognitively intact and the other 'cognitively impaired'. The authors conclude that this means older patients should not be refused TCP based on the presence of cognitive impairment.

Conclusion

The limited information given in the title and abstract suggest the study findings accord with the draft recommendations. The guideline as a whole is based on the principles of person centred care, with recommendation 1.1.1 stating that everyone receiving care throughout transitions should be treated as an individual and 1.5.9 identifying the importance of discharge planning for continuity of care for older people who may be confused. This is supported by the Peel et al. study, which found older people should not be refused transitional care purely because cognitive impairment is present. In addition,

recommendations 1.5.25 and 1.5.26 promote the provision of early supported discharge with a home care and rehabilitation package for all older people.

On this basis, the Peel et al study appears to support existing recommendations and does not seem to provide evidence for new recommendations.

No further action is required.

Reference

Peel N, Chan K and Hubbard R (2015) Outcomes of cognitively impaired older people in transition care. Australasian Journal on Ageing. 34: 53-57

3.8.2 Review area: transition between inpatient hospital settings and community or care home settings for people with end of life care needs

On the basis of title and abstract review, 3 new studies were included under this review area. They were all studies of views and experiences and included 1 systematic review of qualitative evidence.

Summary of evidence based on title and abstract

The new studies relate to several areas of the draft guideline.

Discharge planning for end of life care needs

The recommendations in this section promote joint working between health and social care to ensure that people with end of life care needs are offered general and specialist palliative care on discharge (1.5.21–1.5.23). Recommendation 1.5.24 states that the discharge coordinator should ensure needs are assessed and support provided for the person to die in their preferred place. The qualitative study of practitioner views about discharge home from critical care (Coombs et al 2015) supports the need for these recommendations. The study found that although doctors and nurses viewed the transition positively, it rarely happens because the support required from

community services is complex and difficult to arrange at precisely the time needed.

The study by Venkatasalu et al (2015) also reported findings in this area. The research was a critical examination of the views of practitioner and carer views about a nurse-led palliative care discharge service in an acute hospital setting. The study found that the discharge service acted as a reliable resource and support for facilitating fast-tracking of end of life care patients to their preferred place of death. The authors recommended expanded and earlier involvement of discharge support.

Discharge coordinator

The Venkatasalu et al study (2015) also endorses the recommendations about the importance of a discharge coordinator to support transitions. The nurse, acting as discharge facilitator, was found to act as the conduit between health and social care and as a key support for families. This is exactly the kind of role promoted by recommendations 1.5.1–1.5.2, which apply to all adults transferring from hospital to community or residential settings (including hospice).

Communication and information-sharing (during admission, the hospital stay and discharge)

The importance of the role of the nurse as 'conduit between hospital and social care' (Venkatasalu et al 2015) also illustrates the need for recommendations promoting careful and proactive communication between hospital and community practitioners. In addition, Laging et al (2014) found that residential care staff initiated emergency transfers to hospital when people were at the end of life because they felt isolated from multidisciplinary support. They were also fearful of working outside their capacity by keeping the person in the care facility, so the Laging et al findings do suggest that closer working between hospital and community or care home staff, including regular contact with each other, is an important recommendation for practice.

Before admission to hospital

Laging et al found that another factor contributing to emergency admission from residential care to hospital was that staff could not rely on early planning documents. On the basis of title and abstract, we do not know for sure, although we can assume, this refers to documents recording people's wishes and arrangements around treatment and transitions at the end of life. In this case, the study appears to add weight to the need for recommendations about discussing advance care plans (1.2.3) and the use of communication protocols to record and share end of life wishes (1.3.1).

Conclusion

New evidence about end of life care transitions is limited to 3 studies. On the basis of a title and abstract review, the evidence corroborates findings from research already included in this guideline. Therefore it does not appear that the 3 studies would contradict existing recommendations or provide evidence with which to develop new recommendations. Instead, the new studies strengthen the basis of the recommendations, although without changing the wording, because 'should' is already used.

No further action is required.

New references

Coombs M, Long-Sutehall T, Darlington A, Richardson A (2015) Doctors' and nurses' views and experience of transferring patients from critical care home to die: A qualitative exploratory study

Laging B, Bauer M, Ford R, Nay R (2014) Decision to transfer to hospital from the residential aged care setting: a systematic review of qualitative evidence exploring residential aged care staff experiences.

Venkatasalu Munikumar R; Clarke A, Atkinson J (2015) 'Being a conduit' between hospital and home: stakeholders' views and perceptions of a nurse-led Palliative Care Discharge Facilitator Service in an acute hospital setting.

3.8.3 Review area: admission to inpatient hospital settings from community or care home settings

On the basis of title and abstract review, 1 additional study was included under this review area. The paper reported findings of a systematic review of views and experiences of care home staff on reasons for arranging admission to acute care for care home residents.

Summary of new evidence on basis of title and abstract

Admissions from long-stay care facilities to hospital

Laging et al (2014) is a systematic review of primary qualitative studies published between 1989 and 2011 which explore the reasons why residential care staff at all levels (medically qualified and unqualified) decide to transfer elderly residents to an 'emergency department' (ie acute care facility). A total of 17 studies were appraised and included: 8 were rated excellent; 2 were of very good quality; 6 were rated as good quality and 1 was of reasonable quality: 'The syntheses indicate that several factors influence decisions to transfer, including: limited staffing capacity to assess and manage residents on-site, fear related to working outside one's capacity, isolation from multidisciplinary support and healthcare resources, communication challenges between key decision makers, limited ability to rely on early planning documents and variable perceptions regarding the complexity of care that can be provided in the residential aged care setting' (abstract found on JBI site, pasted in).

The evidence reviewed by the Guideline Committee on this topic is consistent with the Laging review. The relevant recommendations made by the Committee are found in 1.2 (before admission to hospital), and focus on contingency planning, and communication and coordination between the community-based multidisciplinary team and the hospital-based multidisciplinary care team. These recommendations go some way to address issues about limited support from medical staff in the home and community and lack of up-to-date contingency plans, but cannot address shortage of staff in care homes.

Conclusion

The Laging (2014) review supports the 1.2 recommendations, although it would not change the wording (already 'should'). The Committee could not make specific recommendations about staffing levels in care homes. Local relationships between care home staff and community health support staff appear to vary in scope and quality, and the Committee did not choose to make more specific recommendations on advance care and contingency planning, and on communication in relation to people who are at risk of admission. No further action required.

New reference

Laging B, Bauer M, Ford R, Nay R (2014) Decision to transfer to hospital from the residential aged care setting: a systematic review of qualitative evidence exploring residential aged care staff experiences. JBI Database of Systematic Reviews and Implementation Reports. 12: 263-388

3.8.4 Review area: discharge from inpatient hospital settings to community or care home settings

On the basis of title and abstract review, 30 new studies were included in this review area. Of these, 9 were studies of views and experiences and 21 were studies of effectiveness.

Summary of new evidence on basis of title and abstract

The new studies relate to several areas of the draft guideline.

Communication and information-sharing

The recommendations in this section promote joint working between health and social care: to agree clear discharge planning protocols and share these (as well as other relevant information) with both hospital- and community-based multidisciplinary teams (1.5.3–1.5.5). Three new studies support the need for these recommendations. Waring et al (2015) suggested that good hospital discharge relies upon close collaboration and interaction between health and social care actors, and that attention should therefore be paid to the sociocultural boundaries that influence communication in order to help form interventions that support enhanced discharge safety. Similarly, Baillie et al (2014) conclude that staff in acute and community settings need further opportunities to gain better understanding of each other's roles, and build relationships and trust. A study by Doos et al (2014) has additionally highlighted the importance of a comprehensive, coordinated and integrated approach, which also incorporates patients, carers and staff preferences for treatment on discharge from hospital.

Bench et al. (2014) lend support to recommendation 1.5.6, which refers to the timely receipt of discharge summaries: to the patient's GP (within 24 hours) and the patient themselves (on the day of discharge), highlighting that with the appropriate training and support it is feasible for nurses to complete discharge summaries in a busy critical care environment.

Discharge planning

Two studies of views and experiences endorse the need for recommendations about the involvement of the person receiving care in developing and agreeing a discharge plan (1.5.13), which should subsequently take account of the person's social and emotional wellbeing (1.5.14). A National Audit study (2014) reported that patients' experience of care could be improved through increased involvement of users in care planning, discharge planning and post-discharge care, while a review by Chenoweth et al (2015) found that discharge planning and transitional care for patients with dementia are not adequate, and are likely to lead to readmission and other poor health outcomes.

A study by Harvey et al (2014), which looked at the feasibility and impact of a geriatrician-led supported discharge service for older adults living in residential care facilities, also supports recommendations 1.5.13–1.5.14. The authors found that patients who received a care plan and assessment were more satisfied than people in the control group, and showed a significant reduction in outpatient visits.

Two further studies support recommendations 1.5.15 and 1.5.16, emphasising the importance of identifying and involving families and carers in the person's ongoing care and support. Epstein-Lubow et al (2014) found that the inclusion of a family caregiver was associated with a greater rate of completing the Care Transitions Intervention (CTI) for post discharge coaching, and may therefore be a feasible modification to the CTI programme. A systematic review by Allen et al (2014) concluded that 'with the exception of general practitioner and primary care nurse models', most discharge interventions reduce re-hospitalisation and improve patient experience and satisfaction, but further research involving the person and their family/caregiver in transitional care is needed.

Four new studies are in line with recommendation 1.5.19, which outlines the need to provide patients (and carers) with support and education regarding how they can manage their condition after their discharge from hospital. Two

of these (Hyrkas and Wiggins 2014; Hedegaard et al 2014) advocate the use of patient-centred strategies, such as motivational interviewing, in increasing patients' knowledge about and confidence with medication use. Similarly, Burke et al (2014) looked at the 10 domains of the Ideal Transition of Care (ITC) framework, and found that educational and self-management interventions were the most successful in reducing readmissions. A study by Boltz et al (2014) also demonstrated that 'coaching' families (family-centred function-focused-care – FAM-FFC) led to a significant increase in preparedness for caregiving.

Early supported discharge

A meta-analysis by Hofstad (2014) did not find any significant effect for early supported discharge (ESD). The author explicitly attributes this finding to the inclusion of mainly older studies (10–15 years ago), when treatment of stroke patients was less advanced. The author also concludes that the combination and location of care services at discharge should be governed by individual need and multidisciplinary input. The Guideline Committee recommended (1.5.25–1.5.26) that ESD be made available to older people with social care needs, and that the discharge plan should be holistic and designed to address the individual's need for health, social care, and emotional and practical support (recommendation 1.5.14).

After transfer from hospital

The recommendations in this section refer to community-based health and social care practitioners maintaining contact and following-up with the person after they are discharged (1.5.38–1.5.40). A study by Anderson et al (2013) supports the importance of this recommendation, demonstrating that patients who were contacted after discharge were more likely to attend a hospital discharge follow-up appointment and had lower rates of 30-day readmission compared to those who were not contacted. Boling (2014) has reflected upon a study by Dhalla et al (2014), examining the effectiveness of a virtual ward in which patients received care coordination (ie by telephone or email contact as well as clinic or home visits) for several weeks after hospital discharge. This

study concluded, however, that the intervention did not produce any statistically significant effect on either readmissions or death within 30 days of discharge and therefore does not affect the recommendations in the draft guideline.

Remaining studies

A further 12 newly identified studies were considered against the scope and the recommendations. Of these, 5 examined the effectiveness and cost-effectiveness of nurse-led follow-up or discharge support programmes. Two studies found that discharge coordination and follow-up care by nurse managers significantly improved subjective endpoints, such as quality of life and caregiver burden (Lindpaintner et al 2013; García-Fernández et al 2014). However, there was no – or inconclusive – evidence of nurse-led interventions being cost-effective or reducing readmissions (Goldman et al 2014; Hernandez et al 2014; Donald et al 2015).

Another study by Cox et al (2014) sought to evaluate the feasibility of implementing an advanced occupational therapy assistant-led group programme in a sub-acute aged care rehabilitation setting. The authors conclude that the introduction of an advanced occupational therapy assistant to replace an occupational therapist in facilitating a group programme did not result in a decline in patient outcomes. However, the results should be interpreted tentatively given the stated study limitations, and that it refers specifically to comparison of an intervention delivered by different levels of occupational therapy staff. The study does not provide support for any further recommendations.

A study by Canha et al (2013) compared the impact of referral to the National Post Hospital Care Project versus being discharged home. The project was not described although designed to promote continuity of care between hospital and home, which is consistent with guideline recommendations. The authors conclude that the Project was unable to meet the actual needs of stroke patients, although waiting time was reduced.

Similarly, Stroke Unit Trialists (2013) sought to assess the effect of stroke unit care compared with alternative forms of care for people following a stroke. The authors conclude that stroke patients who received organised inpatient care in a stroke unit were more likely to be alive, independent and living at home 1 year after the stroke. Although this does not directly relate to the recommendations on hospital discharge, it does support recommendation 1.4.5 that promotes the treatment of stroke patients in a stroke unit.

Scala and Costa (2014) conducted a pilot study to evaluate the effectiveness of a transitional care coaching intervention based on appreciative inquiry theory. On title and abstract, however, little information can be gleaned as to the nature of the intervention and findings are not described.

A study by Taylor and Harding (2015) looked at the effectiveness of pre-discharge home assessment visits, and found low to moderate quality evidence of these reducing patients' risk of falling. The low to moderate quality of evidence and the use of falls prevention as the primary outcome measure suggest that, on the basis of title and abstract, this study would not provide material on which to base further recommendations. A views and experiences study (Whitehead et al 2014) has also looked at factors which influence occupational therapists' decisions to complete pre-discharge visits. The authors conclude that although the level of impairment was important, the most dependent patients were not necessarily those believed to be the most likely to need a visit.

A study by Allen et al (2015) sought to review discharge summaries, assessing the quality of information received by GPs in acute kidney injury (AKI) patients, and its impact on AKI management and long-term prognosis. On title and abstract, however, little information can be gleaned and findings are not described in any detail.

Similarly, based on title and abstract, little information could be gleaned about the nature of a study by Bakker et al (2014) looking at virtuous healthcare transition for frail elderly.

Conclusion

New evidence about discharge from hospital was found in 31 studies. It does not appear that these studies would contradict existing recommendations or provide evidence with which to develop new recommendations. Instead, the new studies strengthen the basis of the recommendations.

No further action is required.

New references

The National Audit of Intermediate Care (2014) Measuring patient experience: the national audit of intermediate care patient reported experience measure. Age & Ageing. 43: ii6–ii6.

Allen J, Hutchinson A M; Brown R, Livingston P M; (2014) Quality care outcomes following transitional care interventions for older people from hospital to home: a systematic review. BMC Health Services Research. 14: 346.

Allen J, Harrison L, Bisset L (2015) The missing link: hospital discharge letters following acute kidney injury. Journal of Renal Nursing. 7: 20–26.

Anderson S, Marrs J, Vande G, Joseph P, Hanratty R (2013) Implementation of a clinical pharmacy specialist-managed telephonic hospital discharge follow-up program in a patient-centered medical home. Population health management. 16: 235–41.

Baillie L, Gallini A, Corser R, Elworthy G, Scotcher A, Barrand A (2014) Care transitions for frail, older people from acute hospital wards within an integrated healthcare system in England: a qualitative case study. International journal of integrated care. 14: e009.

Bakker T, Nieboer A, Gobbens R, Jedeloo S (2014) Virtuous healthcare transition for frail elderly. . 5: S32.

Bench S, Heelas K, White C, Griffiths P (2014) Providing critical care patients with a personalised discharge summary: A questionnaire survey and retrospective analysis exploring feasibility and effectiveness. Intensive and Critical Care Nursing. 30: 69–76.

Boling P (2014) Managing post-hospital care transitions for older adults challenges and opportunities. JAMA: Journal of the American Medical Association. 312: 1303–1304.

Boltz M, Resnick B, Chippendale T, Galvin J (2014) Testing a Family-Centered Intervention to Promote Functional and Cognitive Recovery in Hospitalized Older Adults. Journal of the American Geriatrics Society. 62: 2398–2407.

Burke R, Guo R, Prochazka A, Misky G (2014) Identifying keys to success in reducing readmissions using the ideal transitions in care framework. BMC health services research. 14: 423.

Canha C, Massano A, Esperto H, Rato J, Ferreira T, Geraldo A (2013) [National Post Hospital Care Project and length of hospitalization of patients with stroke 2010-2011]. Rede Nacional de Cuidados Continuados e Tempo de Internamento dos Doentes com Acidente Vascular Cerebral 2010-2011. 26: 683–8.

Chenoweth L, Kable A, Pond D (2015) Research in hospital discharge procedures addresses gaps in care continuity in the community, but leaves gaping holes for people with dementia: A review of the literature. Australasian Journal on Ageing. 34: 9–14.

Cox R, Mills V, Fleming J, Nalder E (2014) Implementation of an advanced occupational therapy assistant-led groups programme in aged care rehabilitation. Australian Occupational Therapy Journal. 61: 187–193.

Dhalla IA, O'Brien T, Morra D et al (2014) Effect of a post-discharge virtual ward on readmission or death for high-risk patients: a randomized clinical trial. Journal of the American Medical Association. 312: 1305−12.

Donald F, Kilpatrick K, Reid K, Carter N, Bryant-Lukosius D, Martin-Misener R, Kaasalainen S, Harbman P, Marshall D, DiCenso A (2015) Hospital to community transitional care by nurse practitioners: A systematic review of cost-effectiveness. International Journal of Nursing Studies. 52: 436–451.

Doos L, Bradley E, Rushton C, Satchithananda D, Davies S, Kadam U (2014) Heart failure and chronic obstructive pulmonary disease multimorbidity at hospital discharge transition: A study of patient and carer experience. Health Expectations: An International Journal of Public Participation in Healthcare & Health Policy.

Epstein-Lubow G, Baier R, Butterfield K, Gardner R, Babalola E, Coleman E, Gravenstein S (2014) Caregiver Presence and Patient Completion of a Transitional Care Intervention. American Journal of Managed Care. 20: e439–44.

García-Fernández F, Arrabal-Orpez M, Rodríguez-Torres M, Gila-Selas C, Carrascosa-García I, Laguna-Parras J (2014) Effect of hospital case-manager nurses on the level of dependence, satisfaction and caregiver burden in patients with complex chronic disease. Journal of Clinical Nursing. 23: 2814–2821.

Goldman E, Sarkar U, Kessell E, Guzman D, Schneidermann M, Pierluissi E, Walter B, Vittinghoff E, Critchfield J, Kushel M (2014) Support from hospital to home for elders: a randomized trial. Annals of Internal Medicine. 161: 472–481.

Harvey P, Storer M, Berlowitz D, Jackson B, Hutchinson A, Lim Wen K (2014) Feasibility and impact of a post-discharge geriatric evaluation and management service for patients from residential care: the Residential Care Intervention Program in the Elderly (RECIPE). BMC Geriatrics. 14:48

Hedegaard U, Kjeldsen L, Pottegard A, Bak S, Hallas J (2014) Multifaceted intervention including motivational interviewing to support medication adherence after stroke/transient ischemic attack: a randomized trial. Cerebrovascular diseases extra. 4: 221–34.

Hernandez R, Jenkinson D, Vale L, Cuthbertson B (2014) Economic Evaluation of Nurse-Led Intensive Care Follow-Up Programmes Compared with Standard Care: The PRaCTICaL Trial. European Journal of Health Economics. 15: 243–252.

Hofstad H (2014) Scandinavian challenges in geriatric rehabilitation: Early discharge for stroke patients. . 5: S8-S9.

Hyrkas K, Wiggins M (2014) A comparison of usual care, a patient-centred education intervention and motivational interviewing to improve medication adherence and readmissions of adults in an acute-care setting. Journal of Nursing Management. 22: 350-361.

Lindpaintner L, Gasser J, Schramm M, Cina-Tschumi B, Muller B, Beer J (2013) Discharge intervention pilot improves satisfaction for patients and professionals. European journal of internal medicine. 24: 756–62.

Scala E, Costa L (2014) Using Appreciative Inquiry During Care Transitions. Journal of Nursing Care Quality. 29: 44–50.

Stroke Unit Trialists; Collaboration (2013) Organised inpatient (stroke unit) care for stroke. The Cochrane database of systematic reviews. 9: CD000197.

Taylor N, Harding K (2015) Pre-discharge home assessment visits in assisting patients' return to community living: a systematic review and meta-analysis. Journal of Rehabilitation Medicine. 47: 289–299.

Waring J, Marshall F, Bishop S (2015) Understanding the occupational and organizational boundaries to safe hospital discharge. 20: 35–44.

Whitehead P, Fellows K, Sprigg N, Walker M, Drummond A (2014) Who should have a pre-discharge home assessment visit after a stroke? A qualitative study of occupational therapists' views. The British Journal of Occupational Therapy. 77: 384–391.

3.8.5 Review area: reducing 30-day hospital readmissions

On the basis of title and abstract review, 9 studies were included under this review area from the updated search: 4 systematic reviews, 3 RCTs and 2 controlled studies.

Summary of new evidence on basis of title and abstract

The studies related to the following areas in the guideline.

Providing care

One systematic review (Deschodt et al 2014) is in alignment with recommendation 1.4.4 which advises that older people with complex needs should be treated in a specialist geriatrician-led unit or on a specialist geriatrician-led ward. Individual studies in the review showed that an inpatient geriatric consultation team intervention had favourable effects on functional status, readmission and mortality rates; the meta-analysis found a beneficial effect with regard to mortality at 6 and 8 months post-discharge, but no significant impact on readmission.

Communication and information-sharing (on discharge)

The recommendation about sharing updates on the person's health with both the hospital- and community-based teams (1.5.5) is supported by 1 systematic review. Verhaegh et al (2014) reported communication between hospital and primary care as a high intensity transitional care intervention which was effective in reducing short-term readmission rates.

People at risk of hospital readmission

Two studies support recommendation 1.5.27 which emphasises the importance of referring people at risk of hospital readmission to relevant community-based health and social care practitioners before they are discharged. Verhaegh et al (2014) reported care coordination by a nurse to be an effective transitional care intervention to reduce short-term readmissions. An RCT (Burns et al 2014) showed improved outcomes for an intervention group that received an inpatient introductory visit and weekly post-discharge

phone support from a community health worker. However, it should be noted that while the intervention group in the study had a lower readmission rate, this was only a pilot study and the difference was not statistically significant.

After transfer from hospital

Findings from 3 systematic reviews (2 of which are linked) and a pilot RCT corroborate recommendations 1.5.38 and 1.5.40 which advise community-based health and social care staff to maintain contact with the person after discharge by way of regular phone calls and/or home visits. For those at risk of 30-day readmission a GP or community-based nurse should phone or visit people at risk of readmission between 24 and 72 hours after their discharge.

As above, Verhaegh et al (2014) cites care coordination by a nurse and home visits within 3 days of discharge as effective in reducing 30 day readmission rates. Burns et al (2014), a randomised pilot study, also supports this recommendation in part as it demonstrates improved outcomes for people at risk of 30-day readmission who received a series of post-discharge phone calls from a community health worker, although this difference was not statistically significant.

Feltner et al (2014) and Boet et al (2014) (linked systematic reviews) found home visiting programmes and structured telephone support interventions to be effective in improving mortality rates and reducing readmission rates for people with moderate to severe heart failure. While there are no heart failure-specific recommendations in the draft guideline, findings that relate exclusively to a population with heart failure have been extrapolated to the whole population during the guideline development process (see for example Scott 2010).

One retrospective cohort study using a matched retrospective control group (Stranges et al 2015) followed up older people (over 60) who had been scheduled to receive a primary care-based transitional care programme following discharge (to home or assisted living). The intervention is not well described. Although 30-day outcomes were not improved according to the intention to treat analysis, comparison of the group who actually received the

intervention with controls showed significantly fewer readmissions and longer length of stay (11.7 vs 17.3%, respectively; p<.001). Likewise, time to readmission was significantly longer among those receiving the intervention. This study, despite methodological flaws, is consistent with recommendations 1.5.38–1.5.40, on community-based health and social care support after discharge, and timely GP visits for those at risk of readmission.

Remaining studies

Three studies were not relevant to the recommendations in the draft guideline (Dhalla et al 2014, Lee et al 2014 and Linden and Butterworth 2014).

The effectiveness of a virtual ward in which patients received care coordination plus direct care provision from an interprofessional team for several weeks after hospital discharge was examined in Dhalla et al (2014) using an RCT. The findings of this study do not affect the recommendations in the draft guideline as the virtual ward intervention did not produce any statistically significant effect on either readmissions or death.

Lee et al (2014) is a controlled trial which measured the effectiveness of a shared situational awareness (SSA) intervention for older people with heart failure. As there was no significant difference between the groups when measured on 30-day readmissions, it does not affect the recommendations or provide the basis for any new ones.

Linden and Butterworth (2014) is an RCT which measured the effectiveness of a 90-day hospital-based transitional care intervention aimed at people with heart failure or chronic obstructive pulmonary disease (COPD). On title and abstract little information can be gleaned as to the nature of the intervention. However, as there is no statistically significant difference between treatment groups on the 30-day readmission outcome the study does not affect any existing recommendations or appear to provide the basis for any new ones.

Conclusion

The updated search revealed 9 new effectiveness studies for the reducing readmissions review area. On title and abstract alone none of the studies appear to contradict the recommendations in the draft scope.

Findings from the studies corroborate existing recommendations by evidencing the effectiveness of home visits and phone support interventions for adults discharged from hospital to the community with social care needs. Conclusions from some studies also reinforce the importance of follow-up care in the community within 3 days of hospital discharge (24 to 72 hours) for people who are at high risk of 30-day readmission. Some of the studies also strengthen recommendations about sharing information between hospital and community teams by demonstrating the effectiveness of nurse care coordination, community health worker and communication-based transitional care interventions in reducing readmissions.

One systematic review also strengthens the recommendation for specialist geriatric care as it demonstrates the effectiveness of an inpatient geriatric consultant team intervention in reducing readmission rates in older adults with complex needs.

Two studies focus on interventions which are not covered in the existing recommendations: the SSA intervention for older adults with heart failure (Lee et al 2014) and a post-discharge virtual ward (Dhalla et al 2014). However, neither of these studies show a statistically significant positive effect and, as such, there is insubstantial evidence to generate any new recommendations based on findings from either of these studies.

No further action is required.

New references

Boet S, Bould M, Fung L et al (2014) Transfer of learning and patient outcome in simulated crisis resource management: a systematic review Transitional care interventions to prevent readmissions for people with heart failure. Canadian Journal of Anesthesia. 61: 571–82

Burns M, Galbraith A, Ross-Degnan D et al (2014) Feasibility and evaluation of a pilot community health worker intervention to reduce hospital readmissions. International Journal for Quality in Healthcare: Journal of the International Society for Quality in Healthcare 26: 358–65

Deschodt M, Buurman B, Conroy S et al (2014) Effectiveness of geriatric care models in hospitalized patients: Should we cross borders between hospital and home? European Geriatric Medicine 5 (Suppl.1) S17–8

Dhalla I, O'Brien T, Morra D et al (2014) Effect of a postdischarge virtual ward on readmission or death for high-risk patients: a randomized clinical trial. Journal of the American Medical Association. 312: 1305–12

Feltner C, Jones C, Cené C et al (2014) Transitional Care Interventions to Prevent Readmissions for Persons With Heart Failure: A Systematic Review and Meta-analysis. Annals of Internal Medicine. 160: 774–84

Lee J, Kim S, Lam J et al (2014) The effects of shared situational awareness on functional and hospital outcomes of hospitalized older adults with heart failure. Journal of Multidisciplinary Healthcare. 7: 259–65

Linden A and Butterworth S (2014) A Comprehensive Hospital-Based Intervention to Reduce Readmissions for Chronically Ill Patients: A Randomized Controlled Trial. American Journal of Managed Care. 20: 783–92

Stranges P, Marshall V, Walker P, Hall K, Griffith D, Remington T (2015) A Multidisciplinary Intervention for Reducing Readmissions Among Older Adults in a Patient-Centered Medical Home. American Journal of Managed Care. 21: 106–113

Verhaegh K, MacNeil-Vroomen J, Eslami S et al (2014) Chronic Care. Transitional Care Interventions Prevent Hospital Readmissions For Adults With Chronic Illnesses. Health Affairs. 33: 1531–9

3.8.6 Review area: support for carers at transition between inpatient hospital settings and community or care home settings

On the basis of title and abstract review, 4 new studies were included under this review area. Three were effectiveness studies, and 1 (Doos et al 2014) was a views study.

Summary of new evidence based on title and abstract

The new studies relate to several areas of the draft guideline.

Involvement and education of family carers throughout transition

The Boltz (2014) study is a 'comparative' feasibility trial of a multi-component FAM-FFC intervention. While the 'control group' received only 'function-focused care education' (given to patients, as far as can be ascertained), the intervention group received this plus 'environmental assessment and modification [unclear whether hospital or home environment], staff education, individual and family education and partnership in care planning with follow-up after hospitalization for an acute illness'. Patient outcomes included performance in activities of daily living, gait and balance and delirium severity and duration. Family caregiver outcomes included preparedness for caregiving, anxiety, depression, role strain and mutuality, and a significant increase in preparedness for caregiving and a decrease in anxiety and depression from admission to 2 months after discharge was found among those in the intervention group.

It was unclear from the abstract what the specific components of the intervention were or when it was delivered, although it is reasonable to assume it was delivered during an inpatient hospital episode in preparation for discharge. This paper adds weight to recommendations 1.1.3 (involve families and carers in discussions about the carer being given or proposed), 1.1.6 (give people and carers information about diagnosis and treatment), 1.5.7, discharge planning (provide carers with information and support, which could include hands-on training, including practical support and advice), and 1.5.19

(discuss with the person how they manage their condition after their discharge … should provide support and education including 'coaching' … make this available to carers). The guideline (recommendations 1.5.29–1.5.31) also supports family involvement. Recommendations at 1.5.33–1.5.37 are particularly clear on support and training of carers being offered needs-led training and regular review of this, as well as discussion of practical and emotional aspects of providing care. Most of these recommendations 'should' be carried out so no change in wording would be required.

Carer education and training in promoting recovery from stroke and hip fracture

Hebel et al (2014) is a prospective cohort controlled study which assessed the impact of carer training on functional status improvement in patients after stroke. Both groups improved in functioning, but no significant difference in patient improvement (or deterioration) was found after repeated measures up to 12 months. However, the Guideline Committee recommended (1.5.35) that family members and carers of people who had had a stroke should be 'offered' needs-led training in techniques to care for them and to maximise independence. This study does not contradict the suggestion that support should be offered.

Martin-Martin (2014) concerns occupational therapy training in patient handling and ergonomic treatment for patients and carers. This RCT did demonstrate statistically significant decreases in emotional distress during staged assessments during the 6-month follow-up, and significant positive differences were found for the intervention group in anxiety and depression measures. It is not clear how clinically or experientially important the range of improvement on these scales was. This study supports the recommendations on support and training for carers (1.5.33–1.5.37). Although post-stroke support for carers 'should' be offered, the recommendation on other conditions (1.5.36) is slightly weaker ('should consider offering'), and this paper might support a somewhat stronger recommendation, although the Guideline Committee were clearly mindful that individual conditions could not

be covered in detail, and that training to care for people with any or all conditions might not always be appropriate.

Information needs and continuity of care at discharge

Doos et al (2014) is a mixed-methods study exploring views of patients being discharged with heart failure and COPD, and those of their carers. The study identified concerns around lack of information given to patients and carers about medication, lack of clear information on diagnosis and failures in communication and continuity of care after discharge. Participants wanted 'a comprehensive, coordinated and integrated approach to incorporate patients, carers and staff preferences for treatment on discharge from hospital'. A number of recommendations advocate giving information about diagnosis and treatment (1.1.6); coordinating care between hospital and community based care teams (1.5.1); preparing a holistic discharge plan (1.5.14) which is shared with the person and their carers (if the person agrees) (1.5.15); and discussion with the person about how they can manage after discharge, offering support and education to carers if required (1.5.19). The recommendations do currently address the issues raised by this paper, and most are phrased as 'should', so no change to the strength of the recommendations would be required.

Conclusion

New evidence on support for carers at transition is limited to 4 studies. On the basis of a title and abstract review, the evidence corroborates, rather than contradicts, findings from research already included in this guideline. The new studies strengthen the basis of the recommendations, although without changing the wording, because 'should' is almost always already used.

No further action required.

New references

Boltz M, Resnick B, Chippendale T, Galvin J (2014) Testing a Family-Centered Intervention to Promote Functional and Cognitive Recovery in

Hospitalized Older Adults. Journal of the American Geriatrics Society. 62: 2398–2407

Doos L, Bradley E, Rushton C, Satchithananda D, Davies S, Kadam U (2014) Heart failure and chronic obstructive pulmonary disease multi-morbidity at hospital discharge transition: A study of patient and carer experience. Health Expectations: An International Journal of Public Participation in Healthcare & Health Policy

Hebel K, Bieniaszewski L, Kowalewski W (2014) Health education for stroke patient carers: Does it affect functional status improvement in patients after ischemic stroke? Applied Nursing Research. ANR. 27: E7–E12

Martín-Martín L, Valenza-Demet G, Ariza-Vega P, Valenza C, Castellote-Caballero Y, Jiménez-Moleón J (2014) Effectiveness of an occupational therapy intervention in reducing emotional distress in informal caregivers of hip fracture patients: A randomized controlled trial. Clinical Rehabilitation. 28: 772–783

3.8.7 Review area: transitions-related training

No new studies were identified in relation to transitions-related training for health, social care and housing support staff.

3.9 *Evidence to recommendations*

This section of the guideline details the links between the guideline recommendations, the evidence reviews, expert witness testimony and the GC discussions. Section 3.9.1 (see below) provides a summary of the evidence source(s) for each recommendation. Section 3.9.2 provides substantive detail on the evidence for each recommendation, presented in a series of linking evidence to recommendations (LETR tables).

3.9.1 Summary map of recommendations to source(s) of evidence

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GC 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 with less access to services for example, people with communication difficulties or who misuse drugs or alcohol. Support may include help to access advocacy.	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 the person, their carers and all health and social care practitioners involved in someone's move between hospital and home are in regular contact with each other. This is to ensure the transition is coordinated and all arrangements are in place. For more on medicines-related communication and medicines reconciliation during transitions, see sections 1.2 and 1.3 in NICE's guideline on medicines optimisation and section 1.3 in NICE's guideline on managing medicines in care homes.	ELC3
1.1.5 Give people information about their diagnoses and treatment and a complete list of their medicines when they transfer between hospital and home (including their care home). If appropriate, also give this	HA5

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GC consensus)
to their family and carers.	
1.1.6 Offer information in a range of formats, for example: • 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 (see the Accessible Information Standard).	HA1
1.2 Before admission to hospital	
1.2.1 Health and social care practitioners should develop a care plan with adults who have identified social care needs and who are at risk of being admitted to hospital. Include contingency planning for all aspects of the person's life. If they are admitted to hospital, refer to this plan.	GC consensus
1.2.2 If a community-based multidisciplinary team is involved in a person's care that team should give the hospital-based multidisciplinary team a contact name. Also give the named contact to the person and their family or carer.	HA5
1.2.3 Health and social care practitioners and advocates should explain to the person what type of care they might receive. See sections 1.3 and 1.5 of NICE's guideline on patient experience in adult NHS services. Discussions might cover: • place of care • religion, culture and spirituality • daily routines (including the use of medicines and equipment) • 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 • advance care plans • contingency planning • end-of-life care.	HA3

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GC consensus)
1.3 Admission to hospital	
Communication and information sharing	
1.3.1 Develop and use communication protocols and procedures to support admissions.	HA2, expert witness testimony and GC consensus.
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 NICE's guideline on patient experience in adult NHS services.	HD5
1.3.3 Health and social care practitioners, including care home managers and out-of-hours GPs, responsible for transferring people into hospital should ensure that the admitting team is given all available relevant information. This may include: • advance care plans • behavioural issues (triggers to certain behaviours) • care plans • communication needs • communication passport • current medicines • hospital passport • housing status • named carers and next of kin • other profiles containing important information about the person's needs and wishes • preferred places of care.	HA2, MH1 and HD9
1.3.4 For an emergency admission, A&E should ensure that all available, relevant information is given to the admitting team when a person is transferred for an inpatient assessment or to an admissions ward.	HA2
1.3.5 The admitting team should provide the person and their family, carer or advocate with an opportunity to discuss their care. Also provide the following information: • 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	HA1

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GC consensus)
main contact (this is not necessarily the discharge coordinator) • possible options for getting home when they are discharged from hospital • care and treatment after discharge.	
1.3.6 The admitting team must identify whether there is a need for reasonable adjustments to be made to accommodate the person in hospital. This is in line with the Equalities Act 2010. Examples include: • providing communication aids (this might include an interpreter) • ensuring there is enough space around the bed for wheelchair users to move from their bed to their chair • appropriate adjustments for carers.	MH1
Establish a hospital based multi-disciplinary team	
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. The composition of the team should reflect the person's needs and circumstances. Members could include: • doctor • nurse • therapists • mental health practitioner • pharmacist • dietitian • specialists in the person's conditions • social worker • housing specialist • voluntary sector practitioners.	HD1, ELC3, ELC4, EC7
1.3.8 The hospital-based multidisciplinary team should work with the community-based multidisciplinary team to provide coordinated support for older people, from hospital admission through to their discharge home.	HA6, Ec3
Assessment and care planning	
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.	RHR3

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GC consensus)
1.3.10 Start a comprehensive assessment of older people with complex needs at the point of admission and preferably in a specialist unit for older people.	HA4, Ec1
1.4 During the hospital stay	
1.4.1 Record multidisciplinary assessments, prescribed and non-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, 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 their plans for transfer from hospital.	RHR3
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
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 as much as possible during their hospital stay.	HA3
1.5 Discharge from hospital	
Discharge coordinator	
1.5.1 Make a single health or social care practitioner responsible for coordinating the person's discharge from hospital. Create either designated discharge coordinator posts or make members 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 Ensure that the discharge coordinator is a central point of contact for health and social care practitioners, the person and their family during discharge planning. The discharge coordinator should be involved in all decisions about discharge planning.	HD2
Communication and information-sharing	
1.5.3 Health and social care organisations should agree clear discharge planning protocols.	HD1 and GC consensus
1.5.4 Ensure that all health and social care practitioners receive regular briefings on the discharge	HD1 and GC consensus

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GC consensus)
planning protocols.	
1.5.5 During discharge planning, the discharge coordinator should share assessments and updates on the person's health status, including medicines information, 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 that the discharge summary is made available to the person's GP within 24 hours of their discharge. Also ensure that a copy is given to the person on 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: • printed information • face-to-face meetings • phone calls • hands-on training, including practical support and advice.	CS3
1.5.8 The discharge coordinator should provide people who need end-of-life care, their families and carers with details of who to contact about medicine and equipment problems that occur in the 24 hours after discharge.	Expert witness testimony
1.5.9 The discharge coordinator should consider providing people with complex needs, their families and carers, with details of who to contact about medicine and equipment problems that occur in the 24 hours after discharge.	Expert witness testimony
Discharge planning: key principles	
1.5.10 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
1.5.11 Ensure that people do not have to make decisions about long-term residential or nursing care while they are in crisis.	HD8
1.5.12 Ensure that any pressure to make beds available does not result in unplanned and uncoordinated hospital discharges.	HD3
Discharge planning	
1.5.13 From admission, or earlier if possible, the hospital- and community-based multidisciplinary teams should work together to identify and address factors	HD4

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GC consensus)
that could prevent a safe, timely transfer of care from hospital. For example: • homelessness • safeguarding issues • lack of a suitable placement in a care home • the need for assessments for eligibility for health and social care funding.	
1.5.14 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 and HD6
1.5.15 The discharge coordinator should ensure that the discharge plan takes account of the person's social and emotional wellbeing, as well as the practicalities of daily living. Include: • details about the person's condition • information about the person's medicines • contact information after discharge • arrangements for continuing social care support • arrangements for continuing health support • details of other useful community and voluntary services.	HD5, HD6, RHR3 and HD9
1.5.16 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).	RHR5
1.5.17 The discharge coordinator should arrange follow-up care. They should identify practitioners (from primary health, community health, social care, housing and the voluntary sector) and family members who will provide support when the person is discharged and record their details in the discharge plan.	RHR5
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. Ensure that any essential specialist equipment and support are in place at the point of discharge.	ELC3
1.5.19 Once assessment for discharge is complete, the discharge coordinator should agree the plan for ongoing treatment and support with the community-	RHR5

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GC consensus)
based multidisciplinary team.	
1.5.20 A relevant health or social care practitioner should discuss with the person how they can manage their condition after their discharge from hospital. Provide support and education, including 'coaching', if needed. Make this available for carers as well as for people using services.	RHR1
1.5.21 Consider supportive self-management as part of a treatment package for people with depression or other mental health difficulties.	MH2
Discharge planning for end-of-life care needs	
1.5.22 Ensure that people needing end-of-life care are offered both general and specialist palliative care services, according to their needs.	Ec7 and expert witness testimony
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 and ELC5
1.5.24 The discharge coordinator should ensure that 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 Ensure that older people with identified social care needs are offered early supported discharge with a home care and rehabilitation package.	Ec3
1.5.26 Consider 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
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.	RHR4 and RHR6
1.5.28 If a person is homeless, the discharge coordinator should liaise with the local authority housing options team to ensure that they are offered advice and help.	RHR4 and RHR6
Involving carers	
1.5.29 The hospital- and community-based multidisciplinary teams should recognise the value of carers and families as an important source of knowledge about the person's life and needs.	HD5 and HD6

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GC consensus)
1.5.30 With the person's agreement, include the family's and carer'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 team should take account of their: • willingness and ability to provide support • circumstances, needs and aspirations • relationship with the person • need for respite.	CS2
Support and training for carers	
1.5.32 A member of the hospital-based multidisciplinary team should discuss the practical and emotional aspects of providing care with potential carers.	CS3
1.5.33 Ensure that training is available to help carers provide practical support. 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.	Ec6 and GC consensus
1.5.34 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.	Ec6 and GC consensus
1.5.35 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). Take into account the fact that their needs may change over time.	Ec6 and GC consensus
After transfer from hospital	
1.5.36 Community-based health and social care practitioners should maintain contact with the person after they are discharged. Make sure the person knows how to contact them when they need to.	RHR2
1.5.37 An appropriately skilled practitioner should follow up people with palliative care needs within 24 hours of their transfer from hospital to agree plans for their future care.	GC consensus
1.5.38 A GP or community-based nurse should phone or visit people at risk of readmission 24–72 hours after their discharge.	RHR4
1.6 Supporting infrastructure	

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GC consensus)
1.6.1 Ensure that a range of local community health, social care and voluntary sector services is available to support people when they are discharged from hospital. This might include: • reablement (to help people re-learn some of the skills for daily living that they may have lost) • other intermediate care services • practical support for carers • suitable temporary accommodation and support for homeless people.	HD4 and GC consensus
1.6.2 Have a multi-agency plan to address pressures on services, including bed shortages.	HD3 and GC consensus
1.6.3 Ensure that all care providers, including GPs and out-of-hours providers, are kept up to date on the availability of local health, social care and voluntary services for supporting people throughout transitions.	HD4 and ELC4
1.6.4 Ensure that 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.	ELC2 and ELC4
1.7 Training and development	
1.7.1 Ensure that all relevant staff are trained in the hospital discharge process. Training should take place as early as possible in the course of their employment, with regular updates. It could include: • interdisciplinary working between the hospital- and community-based multidisciplinary teams, including working with people using services and their carers • discharge communications • awareness of the local community health, social care and voluntary sector services available to support people during their move from hospital to the community • how to get information about the person's social and home situation (including who is available to support the person) • learning how to assess the person's home environment (home visits) • how to have sensitive discussions with people about end-of-life care	TR1, TR3 and GC consensus

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GC consensus)
- medication review in partnership with the person, including medicines optimisation and adherence - helping people to manage risks effectively so that they can still do things they want to do (risk enablement) - how to arrange, conduct or contribute to assessments for health and social care eligibility.	

3.9.2 Linking evidence to recommendations (LETR) tables

Topic/section heading	Overarching principles of care and support during transition
Recommendations	**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. 1.1.2 Identify and support people at risk of less favourable treatment or with less access to services for example, people with communication difficulties or who misuse drugs or alcohol. Support may include help to access advocacy. 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. **Communication and information-sharing** 1.1.4 Ensure that the person, their carers and all health and social care practitioners involved in someone's move between hospital and home are in regular contact with each other. This is to ensure the transition is coordinated and all arrangements are in place. For more on medicines-related communication and medicines reconciliation during transitions, see sections 1.2 and 1.3 in NICE's guideline on medicines optimisation and section 1.3 in NICE's guideline on managing medicines in care homes. 1.1.5 Give people information about their diagnoses and treatment and a complete list of their medicines when they transfer between hospital and home (including their care home). If appropriate, also give this to their family and carers. 1.1.6 Offer information in a range of formats, for example: - 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 (see the Accessible Information Standard).

Research recommendations	The Guideline Committee did not prioritise this as an area on which to make research recommendations.
Review questions	6. What is the effectiveness of interventions and approaches designed to improve hospital discharge?
	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?
	8 (a) What is the impact of specific interventions to support people with mental health difficulties during transition from general inpatient hospital settings to community or care home settings?
	8 (b) What is the impact of specific interventions to support people with mental health difficulties during admission to general inpatient hospital settings from community or care home settings?
Quality of evidence	The evidence underpinning these recommendations related to improving hospital discharge, transitions for people with mental health difficulties and the hospital admission process.
	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.
	There was a paucity of evidence on transitions for people with mental health difficulties although what was included was of moderate to good quality; views data were notably lacking and effectiveness evidence was contradictory
	Recommendation 1.1.4 was based on evidence reviewed for end of life care transitions comprising good quality views data and 1 moderate quality controlled study of effectiveness.
	Recommendation 1.1.5 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.
Relative value of different outcomes	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.
	The research underpinning 1.1.5 demonstrated that a care navigator for chronically ill older people during transitions was associated with increased quality of life and functionality. Nevertheless, the Guideline Committee 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 multidisciplinary team, rather than from a specific, named individual.
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 Guideline Committee 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	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 (recs 1.1.1, 1.1.2).
	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, 1 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 caregiving; the only differences were less role strain and caregiver preparedness to participate in post-hospital care (recs 1.1.1, 1.1.2, 1.1.3).
	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' experience were not regarded as the hospital's concern (rec 1.1.3).

MH1 There is a small amount of good quality evidence from 1 qualitative study about the hospital admission process for older people with mental health difficulties. 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 healthcare professionals conscientiously communicated with family carers and engaged them in genuine partnership (rec 1.1.3)

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 2 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 1.1.5).

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 (rec 1.1.4).

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 was 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 1.1.6).
Other considerations	Recommendations 1.1.1 are 1.1.2 derived directly from evidence statements 6 and 7 on hospital discharge and supported by Guideline Committee consensus. This included an additional reference concerning help to access advocacy services. 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 Guideline Committee wanted an overarching 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.
	For recommendation 1.1.4, the Committee 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.
	Recommendation 1.1.5 is derived from evidence statement 5 from the hospital admission review area. In discussing the evidence, the Guideline Committee agreed that responsibility for providing information to people with long-term conditions should not necessarily rest with 1 named individual. They felt it could lead other practitioners to neglect to provide information. The Committee therefore agreed the provision of information by a member of the multidisciplinary team should be the focus of the recommendation. Finally, the Committee 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 Committee agreed that for some patients written as well as verbally provided information is valued and this is emphasised in recommendation 1.1.6.

Topic/section heading	Before admission to hospital
Recommendations	1.2.1 Health and social care practitioners should develop a care plan with adults who have identified social care needs and who are at risk of being admitted to hospital. Include contingency planning for all aspects of the person's life. If they are admitted to hospital, refer to this plan. 1.2.2 If a community-based multidisciplinary team is involved in a person's care that team should give the hospital-based multidisciplinary team a contact name. Also give the named contact to the person and their family or carer. 1.2.3 Health and social care practitioners and advocates should explain to the person what type of care they might receive. See sections 1.3 and 1.5 of NICE's guideline on patient experience in adult NHS services. Discussions might cover: • place of care • religion, culture and spirituality • daily routines (including the use of medicines and equipment) • 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 • advance care plans • contingency planning • end-of-life care.
Research recommendations	The Guideline Committee did not prioritise this as an area on which to make research recommendations.
Review questions	6. What is the effectiveness of interventions and approaches designed to improve hospital discharge? 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?
Quality of evidence	The evidence underpinning these recommendations related to improving hospital discharge and the hospital admission process. 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. 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.
Relative value of different outcomes	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 Guideline Committee expertise they agreed that the positive outcomes would be likely to apply for all people with social care needs, not just older people.
Trade-off between benefits and harms	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 soon as possible after 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 adults with social care needs.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the Guideline Committee 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.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	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 2 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 1.2.2). 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).

Other considerations	Recommendation 1.2.1 was derived from Guideline Committee consensus, on the basis of members' expertise. The Committee 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 Committee's view about the importance planning in anticipation of hospital admissions, especially for people identified as being at risk.
	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 Committee agreed that the recommendation should apply more broadly to adults with social care needs. Recommendation 1.2.3 was based in part on evidence statement 3 from the hospital admission review area and also from Committee consensus about the importance of having detailed discussions with people during admission. The aims are to ensure hospital feels a less alien environment, understand the person's wishes and preferences and let them know what to expect while in hospital.

Topic/section heading	Admission to Hospital
Recommendations	**Communication and information sharing**
	1.3.1 Develop and use communication protocols and procedures to support admissions.
	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 NICE's guideline on patient experience in adult NHS services.
	1.3.3 Health and social care practitioners, including care home managers and out-of-hours GPs, responsible for transferring people into hospital should ensure that the admitting team is given all available relevant information. This may include:
	• advance care plans
	• behavioural issues (triggers to certain behaviours)
	• care plans
	• communication needs
	• communication passport
	• current medicines
	• hospital passport
	• housing status
	• named carers and next of kin
	• other profiles containing important information about the person's needs and wishes
	• preferred places of care.

	1.3.4 For an emergency admission, A&E should ensure that all available, relevant information is given to the admitting team when a person is transferred for an inpatient assessment or to an admissions ward.
	1.3.5 The admitting team should provide the person and their family, carer or advocate with an opportunity to discuss their care. Also provide the following information:
	• 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 main contact (this is not necessarily the discharge coordinator)
	• possible options for getting home when they are discharged from hospital
	• care and treatment after discharge.
	1.3.6 The admitting team must identify whether there is a need for reasonable adjustments to be made to accommodate the person in hospital. This is in line with the Equalities Act 2010. Examples include:
	• providing communication aids (this might include an interpreter)
	• ensuring there is enough space around the bed for wheelchair users to move from their bed to their chair
	• appropriate adjustments for carers.
Research recommendations	The following research question is relevant to this topic:
	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 the effects on formal and informal carers, and on avoidable readmissions?
Review questions	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?
	6. What is the effectiveness of interventions and approaches designed to improve hospital discharge?
	8 (a) What is the impact of specific interventions to support people with mental health difficulties during transition from general inpatient hospital settings to community or care home settings?
	8 (b) What is the impact of specific interventions to support people with mental health difficulties during admission to general inpatient hospital settings from community or care home settings?
	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?
	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?
Quality of evidence	The evidence underpinning these recommendations related to improving hospital discharge, transitions for people with mental health difficulties and the hospital admission process.
	Recommendations 1.3.1, 1.3.3, 1.3.4 and 1.3.5 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. It also drew on testimony from an expert witness.
	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.
	Finally, there was a paucity of evidence on transitions for people with mental health difficulties, which informed 1.3.3 and 1.3.6, although what was included was of moderate to good quality; views data were notably lacking and effectiveness evidence was contradictory.
Relative value of different outcomes	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.
	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.
Trade-off between benefits and harms	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.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the Guideline Committee were mindful of potential costs and resource use when making the recommendations. There may be some additional costs linked to the implementation of the recommendation it is unlikely that those will be substantial.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	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 2 transfer documents used in transitional care between nursing homes and hospitals facilitated the communication of advanced directive information (recs 1.3.1, 1.3.3, 1.3.4).
Expert Witness group 3: Claire Henry and GC consensus (rec 1.3.1).

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).

MH1 There is a small amount of good quality evidence from 1 qualitative study about the hospital admission process for older people with mental health difficulties. 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 healthcare professionals conscientiously communicated with family carers and engaged them in genuine partnership (recs 1.3.3, 1.3.6).

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).

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 (rec 1.3.5).
Other considerations	Mostly of the evidence and Guidance Committee discussions relating to these recommendations was connected with information-sharing and communication.
	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 Committee consensus about the vital importance of establishing communication protocols to ensure certain information is shared in a consistent way during hospital admissions.
	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 Committee agreed that communication needs are one aspect often overlooked with the result that vital information is not shared with them.
	Recommendation 1.3.3 is based on 3 evidence statements, which emphasise the importance of ensuring the admitting team is given a range of information about the person's needs, wishes and circumstances. The Committee agreed that the community-based practitioners making the referral to hospital should take responsibility for ensuring that information is provided.
	The Committee derived 1.3.4 from the evidence informing 1.3.3. The recommendation emphasises 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.
	Recommendation 1.3.5 is derived from evidence and Committee consensus that people usually have to ask for information during admission to hospital, rather than being included in discussions or given information.
	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 difficulties, the Committee 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.

Topic/section heading	Establish a hospital based multi-disciplinary team
Recommendations	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. The composition of the team should reflect the person's needs and circumstances. Members could include: • doctor • nurse • therapists • mental health practitioner • pharmacist • dietitian • specialists in the person's conditions • social worker • housing specialist • voluntary sector practitioners. 1.3.8 The hospital-based multidisciplinary team should work with the community-based multidisciplinary team to provide coordinated support for older people, from hospital admission through to their discharge home.
Research recommendations	The Guideline Committee did not prioritise this as an area on which to make research recommendations.
Review questions	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? 6. What is the effectiveness of interventions and approaches designed to improve hospital discharge? 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? 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?
Quality of evidence	The recommendations in support of establishing a hospital-based multidisciplinary 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 multidisciplinary palliative care teams also informed 1 recommendation (1.3.7) in this section. 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. 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 1 moderate quality controlled study of effectiveness plus 2 good quality economic evaluations carried out alongside RCTs.
Relative value of different outcomes	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.

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 multidisciplinary 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 Guideline Committee agreed to recommend early assessment and support from a multidisciplinary team from admission to discharge home. |
Trade-off between benefits and harms	These recommendations were informed by data on views and effectiveness. Combined with Guideline Committee expertise, the data indicated that if people are assigned a multidisciplinary team of practitioners to assess and support them from admission through to discharge, experiences are improved and the outcomes on discharge will be positive.
Economic considerations	Findings on cost-effectiveness are influenced by the costs of the multidisciplinary team, which depend on the mix of professionals in the team, their salaries, contracted working week hours and the 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. It was assumed 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 patients 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.
Evidence statements – numbered evidence statements from which the	HD1 There is a moderate amount of moderate quality evidence that improved interprofessional 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

recommendation(s) were developed	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 standardised 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).
	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).
	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)
	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 2 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 multiprofessional 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 6 weeks (£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 multidisciplinary 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 201) +) 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. An RCT (Eklund et al 2013 +) measured the effects of a multiprofessional 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 1 year, and postponed dependence in ADL up to 6 months (rec 1.3.8). |
| | 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 4 full economic evaluations carried out in different countries, including 1 UK study (Miller et al 2005). The studies were carried out alongside RCTs 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 |

	multidisciplinary team in the UK (Miller et al 2005 ++ n=272 ++). Findings from all 4 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).
Other considerations	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 multidisciplinary hospital-based team but ensuring those practitioners also work closely with their community-based counterparts.
	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 multidisciplinary 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.

Topic/section heading	Assessment and care planning
Recommendations	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. 1.3.10 Start a comprehensive assessment of older people with complex needs at the point of admission and preferably in a specialist unit for older people.
Research recommendations	The following research questions are relevant to this topic. 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? 2.5 How effective are home assessment interventions and approaches designed to improve hospital discharge outcomes?
Review questions	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? 7. What is the effectiveness of interventions and approaches designed to reduce hospital readmissions within 30 days of hospital discharge?
Quality of evidence	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. 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.
Relative value of different outcomes	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.
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 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.
Economic considerations	Recommendations in this area were informed by cost-effectiveness evidence.

Evidence statements – numbered evidence statements from which the recommendation(s) were developed	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 1 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).
	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 1 year, and postponed dependence in ADL up to 6 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).
	Ec1 Evidence from 1 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).
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 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. |
| | Recommendation 1.3.10 is based on good quality economic evidence and effectiveness data synthesised in HA4, which was endorsed by the Guideline Committee. |

Topic/section heading	During the hospital stay
Recommendations	1.4.1 Record multidisciplinary assessments, prescribed and non-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. 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. 1.4.3 Hospital-based practitioners should keep people regularly updated about any changes to their plans for transfer from hospital.
Research recommendations	The following research question is relevant to this topic: 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 the effects on formal and informal carers, and on avoidable readmissions?
Review questions	6. What is the effectiveness of interventions and approaches designed to improve hospital discharge? 7. What is the effectiveness of interventions and approaches designed to reduce hospital readmissions within 30 days of hospital discharge? 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? 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?
Quality of evidence	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. 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.
Relative value of different outcomes	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 outweighed by the benefits. There was good evidence from systematic reviews that early

	assessment of need and discharge planning that involves the patient reduces readmissions.
Trade-off between benefits and harms	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.
Economic considerations	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 Guideline Committee were mindful of potential costs and resource use when making the recommendations
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	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 standardised 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 1.4.1, 1.4.2).
	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).
	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 1 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).
Other considerations	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 multidisciplinary 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 multidisciplinary team members responsibility. 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 emphasised the importance of involving patients in discharge planning.

Topic/section heading	During the hospital stay
Recommendations	1.4.4 Provide care for older people with complex needs in a specialist, geriatrician-led unit or on a specialist geriatrician-led ward. 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.) 1.4.6 Encourage people to follow their usual daily routines as much as possible during their hospital stay.
Research recommendations	The following research question is relevant to this topic: 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?
Review questions	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? 6. What is the effectiveness of interventions and approaches designed to improve the transfer of care from hospital?
Quality of evidence	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.
Relative value of different outcomes	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. 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.
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 older people with complex needs are cared for on a specialist unit 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 ADL would be positively affected and cost reduced due to shorter length of hospital stay. 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 that this recommendation could be followed within existing resources and would benefit individuals and ultimately health and

	social care services.
Economic considerations	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).
	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.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	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 1 year, and postponed dependence in ADL up to 6 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).
	Ec1 Evidence from 1 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).
	Ec2 There is good amount of good and moderate quality economic evidence that shows that stroke unit care provided with early supported discharge and multidisciplinary community care is likely to be cost-effective when compared with standard care. One UK cost-utility study carried out alongside an 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 that 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 (Brady et al 2005 +; Larsen et al 2006 +; Fearon and Langhorne 2012 ++) (rec 1.4.5).
	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 decontextualised 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).
Other considerations	Recommendation 1.4.4 is derived directly from good quality effectiveness and cost-effectiveness evidence, which is synthesised in HA4 and Ec1, with which the Guideline Committee concurred. They discussed whether the recommendation ought to apply to all older people, which could arguably be people of 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.
	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 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
	Finally, recommendation 1.4.6 was derived from HA3. It was the intention of the 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.

Topic/section heading	Discharge from hospital
Recommendations	**Discharge coordinator** 1.5.1 Make a single health or social care practitioner responsible for coordinating the person's discharge from hospital. Create either designated discharge coordinator posts or make members 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. 1.5.2 Ensure that the discharge coordinator is a central point of contact for health and social care practitioners, the person and their family during discharge planning. The discharge coordinator should be involved in all decisions about discharge planning.
Research recommendations	The Guideline Committee did not prioritise this as an area on which to make research recommendations.
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 1 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 Guideline Committee 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 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 healthcare worker acting as discharge coordinator (recs 1.5.1, 1.5.2).
Other considerations	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.

Topic/section heading	Discharge from hospital
Recommendations	**Communication and information sharing**
	1.5.3 Health and social care organisations should agree clear discharge planning protocols.
	1.5.4 Ensure that all health and social care practitioners receive regular briefings on the discharge planning protocols.
	1.5.5 During discharge planning, the discharge coordinator should share assessments and updates on the person's health status, including medicines information, with both the hospital- and community-based multidisciplinary teams.
	1.5.6 The hospital-based doctor responsible for the person's care should ensure that the discharge summary is made available to the person's GP within 24 hours of their discharge. Also ensure that a copy is given to the person on the day they are discharged.
	1.5.7 Make a member of the hospital-based multidisciplinary team responsible for providing carers with information and support. This could include:
	- printed information - face-to-face meetings - phone calls - hands-on training, including practical support and advice.
	1.5.8 The discharge coordinator should provide people who need end-of-life care, their families and carers with details of who to contact about medicine and equipment problems that occur in the 24 hours after discharge.
	1.5.9 The discharge coordinator should consider providing people with complex needs, their families and carers, with details of who to contact about medicine and equipment problems that occur in the 24 hours after discharge.
Research recommendations	The following research questions are relevant to this topic:
	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 the effects on formal and informal carers, and on avoidable readmissions?
	2.5 How effective are home assessment interventions and approaches designed to improve hospital discharge outcomes?
Review questions	6. What is the effectiveness of interventions and approaches designed to improve hospital discharge?
	7. What is the effectiveness of interventions and approaches designed to reduce hospital readmissions within 30 days of hospital discharge?
	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? 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? 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? 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?
Quality of evidence	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. 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 2 effectiveness studies in this area related specifically to support for carers of stroke patients.
Relative value of different outcomes	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. 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.
Trade-off between benefits and harms	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.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the Guideline Committee were mindful of potential costs and resource use when making the recommendations.
Evidence statements –	HD1 There is a moderate amount of moderate quality evidence that improved inter professional communication would ensure

numbered evidence statements from which the recommendation(s) were developed	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 standardised 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, 1.5.4, 1.5.5).
	Consensus (recs 1.5.3, 1.5.4, 1.5.9)
	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, GPs, social community services and other agents (recs 1.5.5, 1.5.6).
	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, while repeated telephone contact from a nurse considerably improved their experience of transition from hospital to home. Another study (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 1 year (rec 1.5.7). Expert witness group 1: Claire Henry (recs 1.5.8, 1.5.9).
Other considerations	Recommendations 1.5.3 and 1.5.4 are linked and both based on evidence statement HD1 which emphasises the importance of communication and information-sharing between professionals that is supported by standardised forms and systems. The Guideline Committee felt that for this to be achieved, health and social care organisations should take responsibility for agreeing discharge planning protocols. In turn the Committee agreed that all relevant practitioners should then be trained to follow the protocols (rec 1.5.4). 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 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. 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 Committee agreed that the discharge summary should be sent to the GP within 24 hours of discharge. As well as ensuring the person being discharged, the GP and the community-based multidisciplinary team receive all relevant information, evidence from the carer support review area emphasised 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. 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. Recommendation 1.5.9 was also based on this evidence and through consensus. The Committee agreed that the discharge coordinator should 'consider' providing this to people with complex needs and their families. To this end the Committee agreed there should be a named individual (whether hospital- or community-based) who can respond to problems occurring within 24 hours of discharge.

Topic/section heading	Discharge planning: key principles
Recommendations	1.5.10 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. 1.5.11 Ensure that people do not have to make decisions about long-term residential or nursing care while they are in crisis. 1.5.12 Ensure that any pressure to make beds available does not result in unplanned and uncoordinated hospital discharges.
Research recommendations	The Guideline Committee did not prioritise this as an area on which to make research recommendations.
Review questions	6. What is the effectiveness of interventions and approaches designed to improve hospital discharge? 8 (a) What is the impact of specific interventions to support people with mental health difficulties during transition from general inpatient hospital settings to community or care home settings? 8 (b) What is the impact of specific interventions to support people with mental health difficulties during admission to general inpatient hospital settings from community or care home settings? 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? 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?
Quality of evidence	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 difficulties although what was included was of moderate to good quality; views data were notably lacking and effectiveness evidence was contradictory 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.
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 1 systematic review, which found that successful transitions for older people involved a discharge coordinator.
Trade-off between benefits and	These recommendations were informed mainly by data on views plus the Guideline Committee's experiences. They indicated that

harms	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 Guideline Committee were mindful of potential costs and resource use when making the recommendations
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	MH1 There is a small amount of good quality evidence from 1 qualitative study about the hospital admission process for older people with mental health difficulties. 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 healthcare professionals conscientiously communicated with family carers and engaged them in genuine partnership (rec 1.5.10).

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 1.5.11).

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 1.5.12). |
| **Other considerations** | Recommendation 1.5.10 was derived directly from MH1. The Guideline Committee was 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 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 1.5.11 was derived from HD8. The 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 1.5.12 is derived from HD3. Acknowledging that pressures on bed occupancy are a reality, the Committee wanted to ensure that even in those circumstances transfers of care are still well coordinated and involve all relevant practitioners.

Topic/section heading	Discharge planning
Recommendations	1.5.13 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. For example: • homelessness • safeguarding issues • lack of a suitable placement in a care home • the need for assessments for eligibility for health and social care funding. 1.5.14 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. 1.5.15 The discharge coordinator should ensure that the discharge plan takes account of the person's social and emotional wellbeing, as well as the practicalities of daily living. Include: • details about the person's condition • information about the person's medicines • contact information after discharge • arrangements for continuing social care support • arrangements for continuing health support • details of other useful community and voluntary services.
Research recommendations	The following research question is relevant to this topic: 2.5 How effective are home assessment interventions and approaches designed to improve hospital discharge outcomes?
Review questions	6. What is the effectiveness of interventions and approaches designed to improve hospital discharge? 7. What is the effectiveness of interventions and approaches designed to reduce hospital readmissions within 30 days of hospital discharge? 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? 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?
Quality of evidence	These recommendations for discharge planning are based on evidence from the linked review areas of hospital discharge and reducing readmissions. 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.
Relative value of different	It was not possible to ascertain and compare the relative value of outcomes of early assessment and planning for discharge

outcomes	because most of the relevant studies were qualitative. However, 2 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.
	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.
	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.
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 the person's 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 Committee was mindful of potential costs and resource use when making the recommendations
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	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, 2 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 (rec 1.5.13).
	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 healthcare worker acting as discharge coordinator (rec 1.5.14).

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, 1 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 in caregivers' emotional coping for depression, anxiety and worry and no reduction in the amount of caregiving; the only differences were less role strain and caregiver preparedness to participate in post-hospital care (recs 1.5.14, 1.5.15).

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

	1.5.15).
	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 1.5.15).
	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 1.5.15).
Other considerations	Recommendation 1.5.13 is derived from evidence statement HD4 and GC 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 1.5.14 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 1.5.15 is based on a good amount of evidence from 3 different evidence statements, HD5, HD6, HD9 and RHR3 about the importance of early discharge planning that addresses all aspects of a person's needs, life and circumstances. The Guideline Committee concurred with the evidence and this is reflected in a strong recommendation.

Topic/section heading	Discharge planning (continued)
Recommendations	1.5.16 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).
	1.5.17 The discharge coordinator should arrange follow-up care. They should identify practitioners (from primary health, community health, social care, housing and the voluntary sector) and family members who will provide support when the person is discharged and record their details in the discharge plan.
	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. Ensure that any essential specialist equipment and support are in place at the point of discharge.
	1.5.19 Once assessment for discharge is complete, the discharge coordinator should agree the plan for ongoing treatment and support with the community-based multidisciplinary team.
Research recommendations	The following research question is relevant to this topic:
	2.5 How effective are home assessment interventions and approaches designed to improve hospital discharge outcomes?
Review questions	7. What is the effectiveness of interventions and approaches designed to reduce hospital readmissions within 30 days of hospital discharge?
	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?
	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?
Quality of evidence	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 1 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 2 moderate to high quality economic evaluations of multidisciplinary palliative care teams in the community.
Relative value of different outcomes	The recommendations about the discharge coordinator linking with the community-based multidisciplinary team over the discharge plan are derived from 2 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.
	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.
Trade-off between benefits and harms	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.
Economic considerations	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.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	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 1 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, GPs, social community services and other agents (recs 1.5.16, 1.5.17, 1.5.19).
	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).
Other considerations	Recommendation 1.5.16 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 Committee agreed this is subject to the person giving consent.
	Recommendations 1.5.17 and 1.5.19 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 Committee felt it was also important that the person and their family should have a record of the names of the community-based practitioners.
	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.

Topic/section heading	Discharge planning (continued)
Recommendations	1.5.20 A relevant health or social care practitioner should discuss with the person how they can manage their condition after their discharge from hospital. Provide support and education, including 'coaching', if needed. Make this available for carers as well as for people using services. 1.5.21 Consider supportive self-management as part of a treatment package for people with depression or other mental health difficulties.
Research recommendations	The following research question is relevant to this topic: 2.2 Which interventions are effective in supporting self-management for people with mental health difficulties who also have a physical condition and are moving into and out of general inpatient hospital settings?
Review questions	7. What is the effectiveness of interventions and approaches designed to reduce hospital readmissions within 30 days of hospital discharge? 8 (a) What is the impact of specific interventions to support people with mental health difficulties during transition from general inpatient hospital settings to community or care home settings? 8 (b) What is the impact of specific interventions to support people with mental health difficulties during admission to general inpatient hospital settings from community or care home settings?
Quality of evidence	These recommendations were based on evidence about reducing hospital readmissions and transitions for people with mental health difficulties. 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 difficulties, although what was included was of moderate to good quality; views data were notably lacking and effectiveness evidence was contradictory.
Relative value of different outcomes	The evidence about self-management for adults with social care needs is taken from effectiveness studies. Although 1 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 difficulties was not as strong but still suggested that positive outcomes could be achieved.
Trade-off between benefits and harms	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.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the Guideline Committee were mindful of potential costs and resource use when making the recommendations. For example, additional costs of training and

	additional staff time for providing care were considered economically justified because of potential positive impacts on health and wellbeing.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	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 caregiver) education for promoting self-management as a vital component for reducing readmissions. Finally, a low quality systematic review (Naylor 2010 -) reported that 3 out of 9 effective interventions included a focus on self-management (rec 1.5.20).
	MH2 The small amount of evidence about supportive self-management for people with mental health difficulties on discharge from inpatient heart failure treatment is conflicting. One RCT 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, 1 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 readmission rates appeared similar (rec 1.5.21).
Other considerations	Recommendation 1.5.20 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 Committee also agreed that the same coaching about managing conditions should also be offered to carers. Recommendation 1.5.21 is linked to 1.5.20 but derived from MH2. Given that MH2 is based on a small amount of mixed quality evidence, the Committee agreed this should be a weaker a recommendation. The evidence was specifically focused on people with depression and the Committee agreed to extend the recommendation to include other mental health difficulties.

Topic/section heading	Discharge planning for end of life care needs
Recommendations	1.5.22 Ensure that people needing end-of-life care are offered both general and specialist palliative care services, according to their needs. 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. 1.5.24 The discharge coordinator should ensure that people who have end-of-life care needs are assessed and support is in place so they can die in their preferred place.
Research recommendations	The Guideline Committee did not prioritise this as an area on which to make research recommendations.
Review questions	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? 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?
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 1 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 as 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 3 out of 4 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 readmissions 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.
Evidence statements – numbered evidence statements from which the recommendation(s)	Ec7 Multiprofessional palliative care teams were found to be cost-effective, albeit with some caution. Two UK RCTs examined the cost-effectiveness of multiprofessional palliative care teams for 2 sub-groups of the population covered in the scope. The first (n=46 ++) showed that

were developed	for people with advanced MS a multiprofessional palliative care team (similar to a 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 12 weeks, 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 multiprofessional 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 6 weeks (£1,422, 95% CI 897–2101 vs £1,408, 95% CI 899–2023) although the authors reported that costs varied greatly between individuals (rec 1.5.22).
	GC Opinion and expert Witness (rec 1.5.22).
	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 patients' social care needs were ignored when support packages were being established for discharge home. One UK paper (Ingleton 2000 ++) found that ambulance service protocols sometimes prevent patients being transferred from home to hospice or hospital. Finally, 1 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 (recs 1.5.23, 1.5.24).
	ELC5 There is a small amount of evidence from 1 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, 1.5.24).
Other considerations	Recommendations 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 places a responsibility on the discharge coordinator to support people with end of life care needs to die in their preferred place. The Committee agreed that this is where the discharge coordinator has a key role to play.

Topic/section heading	Early supported discharge
Recommendations	1.5.25 Ensure that older people with identified social care needs are offered early supported discharge with a home care and rehabilitation package.
	1.5.26 Consider early supported discharge with a home care and rehabilitation package provided by a community-based multidisciplinary team for adults with identified social care needs.
Research recommendations	The following research question is relevant to this topic:
	3.5 How effective are home assessment interventions and approaches designed to improve hospital discharge outcomes?
Review questions	6. What is the effectiveness of interventions and approaches designed to improve the transfer of care from hospital?
Quality of evidence	Both evidence statements are based on good quality economic evidence located under the hospital discharge review area.
Relative value of different outcomes	The recommendations are derived from evidence of cost-effectiveness and supported by Committee expertise. This meant the Committee could establish the value of early supported discharge and rehabilitation for older people specifically and for adults with social care needs more generally.
Trade-off between benefits and harms	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.
Economic considerations	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.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	Ec3 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 RCTs 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 multidisciplinary team in the UK (n=272 ++). Findings from all 4 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-hour 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 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). The 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, 1.5.26).
Other considerations	Recommendation 1.5.25 was derived directly from economic evidence statement 3, which synthesises 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.

Topic/section heading	People at risk of hospital readmission
Recommendations	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. 1.5.28 If a person is homeless, the discharge coordinator should liaise with the local authority housing options team to ensure that they are offered advice and help.
Research recommendations	The Guideline Committee did not prioritise this as an area on which to make research recommendations.
Review questions	7. What is the effectiveness of interventions and approaches designed to reduce hospital readmissions 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 re-admitted to hospital within 30 days. Considering the equalities impact assessment as well as evidence from 1 RCT, the Committee agreed that homeless people in particular would benefit from follow up support.
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 of stay 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 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 1 of 2 most effective

	multicomponent 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 (recs 1.5.27, 1.5.28).
	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 RCT (Sadowski 2009 +) found that when housing was offered on discharge from hospital, followed by placement in long-tern housing, the intervention groups had statistically significantly lower readmissions (as well as hospital days and emergency department visits) (recs 1.5.27, 1.5.28).
Other considerations	Recommendations 1.5.27 and 1.5.28 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, which highlights evidence from an RCT that a housing placement reduces readmissions, the Committee chose to make a specific recommendation concerning homeless people. This population is particularly at risk of readmission and 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.

Topic/section heading	Involving carers
Recommendations	1.5.29 The hospital- and community-based multidisciplinary teams should recognise the value of carers and families as an important source of knowledge about the person's life and needs. 1.5.30 With the person's agreement, include the family's and carer's views and wishes in discharge planning. 1.5.31 If the discharge plan involves support from family or carers, the hospital-based multidisciplinary team should take account of their: • willingness and ability to provide support • circumstances, needs and aspirations • relationship with the person • need for respite.
Research recommendations	The Guideline Committee did not prioritise this as an area on which to make research recommendations.
Review questions	6. What is the effectiveness of interventions and approaches designed to improve hospital discharge? 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? 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?
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 2 effectiveness studies with an RCT design for carer support related specifically to carers of stroke patients. Economic evaluations were carried out alongside those 2 effectiveness studies.
Relative value of different outcomes	The absence of relevant effectiveness studies 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 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	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, 1.5.30).
	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, 1 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 caregiving; the only differences were less role strain and caregiver preparedness to participate in post-hospital care (recs 1.5.29, 1.5.30).
	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).
Other	Recommendations 1.5.29 and 1.5.30 are both derived from HD5 and HD6, which emphasise the importance of treating the whole

considerations	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 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.

Topic/section heading	Support and training for carers
Recommendations	1.5.32 A member of the hospital-based multidisciplinary team should discuss the practical and emotional aspects of providing care with potential carers. 1.5.33 Ensure that training is available to help carers provide practical support. 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. 1.5.34 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. 1.5.35 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). Take into account the fact that their needs may change over time.
Research recommendations	The Guideline Committee did not prioritise this as an area on which to make research recommendations.
Review questions	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? 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?
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 2 effectiveness studies with RCT design for carer support related specifically to carers of stroke patients. Economic evaluations were carried out alongside those 2 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	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, while 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 1 year (rec 1.5.32).
	Ec6 One UK cost-utility study that was carried out alongside an RCT was identified (n=300, ++). The intervention referred to 3 to 5 training sessions for carers (30–40 minutes) on a stroke rehabilitation unit compared to stroke rehabilitation 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 2 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 with cross reference to the NICE stroke rehabilitation guideline , 1.5.34, 1.5.35)
Other considerations	Recommendation 1.5.32 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 multidisciplinary team should discuss the practical and emotional aspects of providing care rather than simply give carers an information leaflet.
	Recommendations 1.5.33, 1.5.34 and 1.5.35 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 (1.5.34). Recommendations 1.5.33 and 1.5.35 are similar to existing NICE recommendations from the stroke rehabilitation guideline. However, for 1.5.33, the Committee wished to update the reference to the type of training provided and emphasise that, in light of the evidence, it may be better to deliver the training at home, after discharge from hospital.

Topic/section heading	After transfer from hospital
Recommendations	1.5.36 Community-based health and social care practitioners should maintain contact with the person after they are discharged. Make sure the person knows how to contact them when they need to.
	1.5.37 An appropriately skilled practitioner should follow up people with palliative care needs within 24 hours of their transfer from hospital to agree plans for their future care.
	1.5.38 A GP or community-based nurse should phone or visit people at risk of readmission 24–72 hours after their discharge.
Research recommendations	The following research question is relevant to this topic:
	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 the effects on formal and informal carers, and on avoidable readmissions?
Review questions	7. What is the effectiveness of interventions and approaches designed to reduce hospital readmissions within 30 days of hospital discharge?
Quality of evidence	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.
Relative value of different outcomes	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.
	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.
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 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.
Economic considerations	Although there was no evidence on costs, the Committee felt the individual- and system-level benefits would outweigh additional costs incurred.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	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 1 of 2 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 2 RCTs that included post-discharge telephone calls and which did not report significant effects. Similarly, 2 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 1.5.36).
	Consensus (rec 1.5.37)
	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 1 of 2 most effective multicomponent 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 1.5.38).
Other considerations	Recommendation 1.5.36 is derived from RHR2, which synthesises 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 (1.5.37) and the 24-hour time frame reflects the urgency often associated with supporting people at the end of life. Finally, 1.5.38 is derived directly from evidence in RHR4. The Committee were unanimous in their agreement about this recommendation, including that it should be focused on people at risk of admission, rather than just older people and that the timeframe should be 24–72 hours.

Topic/section heading	Supporting infrastructure
Recommendations	1.6.1 Ensure that a range of local community health, social care and voluntary sector services is available to support people when they are discharged from hospital. This might include: • reablement (to help people re-learn some of the skills for daily living that they may have lost) • other intermediate care services • practical support for carers • suitable temporary accommodation and support for homeless people. 1.6.2 Have a multi-agency plan to address pressures on services, including bed shortages. 1.6.3 Ensure that all care providers, including GPs and out-of-hours providers, are kept up to date on the availability of local health, social care and voluntary services for supporting people throughout transitions. 1.6.4 Ensure that 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.
Research recommendations	The Guideline Committee did not prioritise this as an area on which to make research recommendations.
Review questions	6. What is the effectiveness of interventions and approaches designed to improve hospital discharge? 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? 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?
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 1 moderate quality controlled study of effectiveness.
Relative value of different outcomes	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. Evidence in favour of ensuring that out-of-hours providers can access a record of people's end of life care preferences was from qualitative studies so it was not possible to ascertain and

	compare the relative value of associated outcomes.
Trade-off between benefits and harms	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. 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.
Economic considerations	Most of economic evidence on rehabilitation and intermediate care (with the exception of 1 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	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, 2 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). 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 1.6.2).
	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 hospitalisation with families of nursing home residents during the living-dying interval (rec 1.6.4).
	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)
Other considerations	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. Recommendation 1.6.2 is derived directly from HD3 and Guideline Committee consensus was that plans should be 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 (including voluntary services), all providers should be made aware of them.
	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 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.

Topic/section heading	Training and development
Recommendations	1.7.1 Ensure that all relevant staff are trained in the hospital discharge process. Training should take place as early as possible in the course of their employment, with regular updates. It could include: • interdisciplinary working between the hospital- and community-based multidisciplinary teams, including working with people using services and their carers • discharge communications • awareness of the local community health, social care and voluntary sector services available to support people during their move from hospital to the community • how to get information about the person's social and home situation (including who is available to support the person) • learning how to assess the person's home environment (home visits) • how to have sensitive discussions with people about end-of-life care • medication review in partnership with the person, including medicines optimisation and adherence • helping people to manage risks effectively so that they can still do things they want to do (risk enablement) • how to arrange, conduct or contribute to assessments for health and social care eligibility.
Research recommendations	The following research question is relevant to this topic: 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 the effects on formal and informal carers, and on avoidable readmissions?
Review questions	12. What is the impact of training to support transitions between inpatient hospital settings and community or care home settings?
Quality of evidence	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.
Relative value of different outcomes	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 Guideline Committee expertise provided sufficient confidence that training for hospital- and community-based staff 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.
Trade-off between benefits and harms	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.
Economic considerations	The development of the training programme will be associated with additional costs to hospital trusts and local authorities and there will be also ongoing 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 benefits to service users' and carers' health and wellbeing 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.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	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-focused and takes account of options for community support (rec 1.7.1).
	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% 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 benefited 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 lifestyle 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).
Other considerations	Recommendation 1.7.1 is based on TR1 and TR3. 1.7.1 is a strong 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 and they reached a consensus that the recommendation would benefit all relevant staff including community based health and social care professionals. 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.

4   Implementation: getting started

This section highlights 3 areas of the transition between inpatient hospital settings and community or care home settings for adults with social care needs guideline that were identified as a focus for implementation. It explains the reasons why the change needs to happen (given in the box at the start of each area). The section also gives information on resources and examples from practice to help with implementation.

The challenge: improving understanding of person-centred care

See recommendations 1.1.1, 1.1.2, 1.1.3, 1.1.5, 1.3.3, 1.3.6, 1.4.6, 1.5.7, 1.5.14, 1.5.24, 1.5.29, 1.5.30, 1.5.31.

Providing person-centred care can ensure that:

- everyone with care and support needs is recognised as an individual and as an equal partner who can make informed choices about their own care
- when a hospital stay is needed, people who need care and support

> continue to experience a seamless service that suits their needs and meets their goals for care, rather than the needs of services
>
> - carers are recognised for the understanding they bring about a person's life and preferences, and are given the support they need to sustain their own wellbeing
>
> - practice is safe and effective, this in turn can reduce the long-term costs associated with poor quality care

Managers and practitioners working in multidisciplinary hospital- and community-based teams need to develop a common understanding about person-centred care. That way they can better organise services around the needs of each person, especially as they transfer between care settings. But current pressures on services can mean that they feel unable to offer personalised care and support.

What can health and social care managers and practitioners do to help?

- Use resources that focus on how to improve this area, such as:
  - those produced by National Voices, a national coalition of charities that supports a strong patient and citizen voice and the Think Local Act Personal partnership
  - the Social Care Institute for Excellence's Co-production in social care: what it is and how to do it.
  - Chapter 7 of the Care Act 2014: statutory guidance for implementation if people need additional support. For example, if they need help from an advocate to make choices because they have communication difficulties or lack capacity and have no support from family, carers or friends.

- Use this guideline, along with the 'Care Act 2014: statutory guidance for implementation' and resources such as NHS England's Commitment to carers, to understand your responsibilities towards carers in their own right, as well as the role that families and carers play in helping people making choices about their care.

- Use this guideline in local forums, and with national bodies involving health and social care practitioners, to review the knowledge, skills and competencies they need to provide person-centred care and support.
- Understand and consistently apply the [Accessible Information Standard](#) to provide information in formats that disabled people and, if appropriate, their carers and families, can understand. This standard will also help you ensure that people receive the right support to help them to communicate.

The challenge: ensuring health and social care practitioners communicate effectively

See recommendations 1.1.4, 1.3.1, 1.3.2, 1.3.3, 1.4.1, 1.5.3.

Good communication systems enable:

- improved coordination of care and, therefore, a better experience for the person and improved outcomes
- practitioners to have a clear understanding about people's health, social care and support needs and preferences and the role practitioners need to play to promote wellbeing

They might also enable more efficient and cost-effective use of resources.

Poor coordination of care, and poor communication between and within teams, can lead to poorer outcomes and a poor experience of care. Local health and social care organisations need to establish communications protocols, procedures and systems. These should make best use of technology to enable data-sharing between all practitioners involved in the care and support of people in the area (subject to information governance protocols).

Protocols for sharing information with people, their families and carers also need to be established to ensure that all communication arrangements are understood and used by all relevant practitioners.

What can health and social care managers do to help?

- Understand the law on information sharing in health and social care and ensure staff are trained in the subject. See the Health and Social Care Information Centre's Rules for sharing information and the Care Quality Commission's Code of practice on confidential personal information.

- Consider how practical examples of using technology and innovation to improve coordination can be applied locally, for example:

  – An electronic palliative care coordination system (EPaCCS) can help practitioners share a person's end-of-life care needs and preferences. An economic evaluation of established EPaCCS early implementer sites (by NHS Improving Quality) showed that these systems helped up to 80% of people who were included in the system to die in their place of choice. It was also claimed that EPaCCS saved the NHS money by reducing acute hospital admissions and bed use.

- Take forward proposals in the National Information Board's framework for action, Personalised health and care 2020: using data and technology to transform the lives of patients and citizens. Use its case studies as examples. The aim is that all care records will be digital, real-time and interoperable by 2020. In the meantime, keep up to date with the Health and Social Care Information Centre's Transfer of Care initiative. This is testing improvements such as secure email between care homes and hospitals, standards for electronic discharge notices and improved use of technology in the home.

The challenge: changing how community- and hospital-based staff work together to ensure coordinated, person-centred support

See recommendations 1.2.1, 1.2.2, 1.3.3, 1.3.7, 1.3.8, 1.5.1, 1.7.1.

Changing working practices across multidisciplinary teams is likely to lead to:

- a better experience of transitions between hospital and home and improved wellbeing for people with care and support needs, their carers and families

- greater job satisfaction
- more efficient and cost-effective use of resources

To achieve person-centred coordinated care for people moving between care settings may need changes in culture and local practice.

Managers need to assess the factors affecting integrated working in their areas, and motivate and support practitioners to adopt attitudes and behaviours that support person-centred approaches. Changing attitudes can be challenging, particularly if there are pressures on staff time and resources, and local capacity (or knowledge of alternative sources of support) is limited.

What can health and social care managers do to help?

- Review local relationships across health, social care, housing and the voluntary sector and identify areas for improvement. Resources and organisations that can help include:
  - The Local Government Association, NHS England and their partners' resources and tools to improve integrated working through the Better Care Programme. The LGA's Integration and the Better Care Fund is a summary of programmes relating to integrated working for health and wellbeing boards, local authorities and their partners in the health and voluntary sectors. This includes the Better Care Exchange, which offers the opportunity to share learning across systems, and a series of practice guides, such as How to work together across health, care and beyond
  - The Department of Health-funded evaluation of the Homeless Hospital Discharge Fund shows that joint working across sectors reduces delayed transfers of care for homeless people with social care needs.
  - The Social Care Institute for Excellence's Dying at home: the case for integrated working provides examples from practice, including case studies showing how working together can help to meet people's preferences.

- Establish a change programme that includes staff training based on the principles of the Care Act and the Mental Capacity Act, and the ambitions set out in the NHS Five Year Forward View. Depending on local needs and circumstances, the programme could draw on approaches identified in the Social Care Institute for Excellence's Organisational change in social care study resource.

Need more help?

Further resources <mark>[add a link to the NICE website tools and resources web page of the guideline]</mark> are available from NICE that may help to support implementation.

- annual indicators for use in the Quality and Outcomes Framework (QOF) for the UK. See the process and the NICE menu
- uptake data about guideline recommendations and quality standard measures.

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6 Related NICE guidance

Details of [related guidance](#) are correct at the time of publication of the guideline (November 2015).

Published

- [Older people with social care needs and multiple long-term conditions](#). NICE guideline NG22 (2015)

- [Home care: delivering personal care and practical support to older people living in their own homes](#). NICE guideline NG21 (2015)

- [Excess winter deaths and morbidity and the health risks associated with cold homes](#). NICE guideline NG6 (2015).

- [Medicines optimisation](#). NICE guideline NG5 (2015).

- [Managing medicines in care homes](#). NICE guideline SC1 (2014).

- [Mental well-being of people in care homes](#). NICE quality standard 50 (2013).

- [Stroke rehabilitation: Long-term rehabilitation after stroke](#). NICE guideline CG162 (2013).

- [Supporting people to live well with dementia](#). NICE quality standard 30 (2013).

- [Patient experience in adult NHS services: improving the experience of care for people using adult NHS services](#). NICE guideline CG138 (2012).

- [Patient experience in adult NHS services](#). NICE quality standard 15 (2012).

- [End of life care for adults](#). NICE quality standard 13 (2011).

- [Hip fracture: The management of hip fracture in adults](). NICE guideline CG124 (2011).
- [Service user experience in adult mental health](). NICE guideline CG136 (2011).
- [Service user experience in adult mental health](). NICE quality standard 14 (2011).
- [Dementia](). NICE quality standard 1 (2010).
- [Rehabilitation after critical illness](). NICE guideline CG83 (2009).
- [Dementia: Supporting people with dementia and their carers in health and social care](). NICE guideline CG42 (2006).
- [Improving supportive and palliative care for adults with cancer](). NICE cancer service guideline (2004).

In development

NICE is [developing]() the following guidance:

- Older people: independence and mental wellbeing. NICE guideline. Publication expected December 2015.
- Care of the dying adult. NICE guideline. Publication expected December 2015.
- Transition between inpatient mental health settings and community and care home settings. NICE guideline. Publication expected August 2016.
- Care and support of older people with learning difficulties. NICE guideline. Publication expected September 2017.

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Declarations of interests

The following members of the Guideline Committee made declarations of interest. All other members of the group stated that they had no interests to 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
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Margaret Lally	While at the British Red Cross, contributed to documents on the need to improve transitionary 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
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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	Non-personal	None

	aims to make	pecuniary interest	
Manoj Mistry	In October appointed Lay Member of the Prescribed Specialised Services Advisory Group, Department of Health, London.	Non-personal pecuniary interest	None
Manoj Mistry	In September 2015 appointed PPI representative at the Centre for Engagement and Involvement, Faculty of Medicine and Human Sciences at the University of Manchester.	Non-personal pecuniary interest	None
Manoj Mistry	In August 2015 appointed Patient-Public Representative for the new postgraduate 'Advanced Clinical Skills' course at Manchester Pharmacy School, The University of Manchester, England, UK .	Non-personal pecuniary interest	None
Manoj Mistry	In May 2015 appointed a member of the Study Steering Committee for the research project: '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)	Non-personal pecuniary interest	None
Manoj Mistry	In April 2015 appointed onto a PPI Panel assisting research into: Information Systems: " Dashboards: Monitoring and Managing from Ward to Board " at the University of Leeds.	Non-personal pecuniary interest	None
Manoj Mistry	In March 2105 appointed a member of the " Patient and Public Involvement Group ", Liverpool Clinical Trials Unit, at the University of Liverpool.	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	Personal non-pecuniary interest	None

	and Care, Greater Manchester		
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 services of the NHS as a whole, they can only be resolved by the Department of Health	Personal and non-personal pecuniary interest	None
Kathleen Sutherland-Cash	Involved in work representing the interests of people with learning difficulties	Non-personal pecuniary interest	None

8   Glossary and abbreviations

Glossary

Advance care plan

An advance care plan could include:

- an advance statement (a statement of wishes and preferences)
- an advance decision to refuse treatment
- the appointment of a personal welfare Lasting Power of Attorney.

Discharge plan

A document that describes the coordination of care and support for discharge from hospital. It is a working document for the multidisciplinary teams.

Discharge summary

A summary of what happened during admission and the hospital stay from a medical perspective. It might include the diagnosis, outcomes of investigations, changes to treatment and the medicines started or stopped, or dosage changes and the reasons why.

Early supported discharge

A multidisciplinary service that aims to allow patients to return home from hospital early and receive more rehabilitation support at home.

Hospital passport

A document for people who have a learning disability. It provides hospital staff with information to help with care planning and discharge arrangements.

Medication review

A structured, critical examination of a person's medicines. The aim is to agree the treatment with them, make sure the medication is being used effectively, minimise medication-related problems and reduce waste.

Medicines optimisation

A person-centred approach to safe and effective medicines use, to ensure that people get the best possible outcomes. Covers both prescription and non-prescription medicines.

Medicines reconciliation

Identifying the most accurate list of a person's current medicines – including name, dosage and frequency – and comparing them with the medicines the person is taking. The aim is to spot any discrepancies and document any changes to ensure that the list is complete, up to date and accurately communicated.

Step-up facilities

Intermediate care settings that people are referred to from community settings. The aim is to prevent unnecessary acute hospital admissions or premature admissions to long-term care.

Supportive self-management

Supportive self-management is based on the principle that people should be active partners in supporting their own health and wellbeing, rather than being passive recipients of care. Self-management techniques help people build the confidence to make informed decisions about their own health and social care and reach any related goals.

Terms used in this guideline

Carer

A carer is someone who helps another person, usually a relative or friend, in their day-to-day life. This is not the same as someone who provides care professionally or through a voluntary organisation.

Coaching

Giving someone instructions to support them through hospital discharge. For example in how to use their medicines effectively, or how to identify possible triggers that indicate their condition is deteriorating and what to do about it.

Community-based multidisciplinary team

Members of a community-based multidisciplinary team could include:

- GP
- community nurse
- community mental health practitioner
- social worker
- housing officer
- voluntary sector practitioners
- community pharmacist
- therapists

- registered manager.

Comprehensive assessment of older people with complex needs

A comprehensive geriatric assessment is an interdisciplinary diagnostic process to determine the medical, psychological and functional capability of someone who is frail and old. The aim is to develop a coordinated, integrated plan for treatment and long-term support.

Older people

Generally this refers to people aged 65 years and over. But it could refer to people who are younger, depending on their general health, needs and circumstances.

For other social care terms see the Think Local, Act Personal Care and Support Jargon Buster.

Abbreviations – terms from included studies

Abbreviation	Term
ABI	acquired brain injury
ACE	acute care for elders
ACP	advanced care planning
AE	adverse events
ADL	activities of daily living
AKI	acute kidney injury
AHS	area health service
ALF	assisted living facility
CCG	clinical commissioning group
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
EHM	electronic home monitoring
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
FAM-FFC	family centred function focussed care
GC	Guideline Committee
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
ITC	ideal transfer of care
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
PCDI	patient centred discharge instructions
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
SSA	shared situational awareness
SNF	skilled nursing facility

SD	standard deviation
SF-36	Short Form (36) health survey
WMD	weighted mean difference
ZBI	Zarit burden interview

About this guideline

What does this guideline cover?

The Department of Health (DH) asked the National Institute for Health and Care Excellence (NICE) to produce this guideline on transition between inpatient hospital settings and community or care home settings for adults with social care needs (see the scope).

The recommendations are based on the best available evidence. They were developed by the Guideline Committee – for membership see Section 7.

For more information on how NICE guidelines are developed, see Developing NICE Guidelines: The Manual.

Other information

We will develop a pathway and information for the public and tools to help organisations put this guideline into practice. Details will be available on our website after the guideline has been issued.

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