

## **Findings and Critical Appraisal Tables**

**Review question 1. Home based intermediate care:**

- a) **What is the effectiveness and cost effectiveness of home based intermediate care?**
- b) **What are the views and experiences of people using services, their families and carers in relation to home based intermediate care?**
- c) **What are the views and experiences of health, social care and other practitioners about home based intermediate care?**

**Research question 1 – Findings tables – Effectiveness**

1. Crotty M, Giles LC, Halbert J et al. (2008) Home versus day rehabilitation: A randomised controlled trial. Age and Ageing 37: 628-33

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> ‘To ... assess the effect of home versus day rehabilitation on patient outcomes’ (p628).</p> <p><b>Methodology:</b> RCT - Participants randomised to hospital based day rehabilitation or home based rehabilitation.</p> <p><b>Country:</b> Australia – Adelaide.</p>	<p><b>Participants:</b> Service users and their families, partners and carers - Medically stable patients referred for ambulatory rehabilitation at discharge from hospital. Patients were eligible if they were assessed as requiring at least 12 rehabilitation sessions by a rehabilitation triage nurse. Reasons for admission to acute care included stroke, knee replacement, or ‘other neurological injury’ (p630).</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Day hospital rehabilitation – Mean age 71.2</li> </ul>	<p><b>Findings - effect sizes:</b> NB. Effect sizes not reported by the authors. Effect sizes presented here were calculated by the review team.</p> <p><b>Service user related outcomes –</b> <b>Mass:</b> Day hospital rehabilitation – baseline 72.3 (SD=16.9); 3 months 74.0 (SD=14.5); change -0.2 (SD=3.7). Home based rehabilitation - baseline 75.5 (SD=19.4); 3 months 75.1 (SD=18.6); change -0.7 (SD=4.1). Effect sizes for mass: Baseline: d=0.1757; 95% Confidence Interval -0.0 838 to 0.4353; 3-months: d = 0.0659; 95% CI -0.1933 to 0.325; Change: d = -0.128; 95% CI -0.3873 to 0.1314.</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

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<p><b>Source of funding:</b> Government - South Australian Department of Health.</p>	<p>years (SD=3.4). Home based rehabilitation – Mean age 72.2 years (SD=14.8).</p> <ul style="list-style-type: none"> <li>• Sex - Total sample – Female 52% (n=120). Male 48% (n=109). Not reported by group.</li> <li>• Ethnicity - Not reported.</li> <li>• Religion/belief - Not reported.</li> <li>• Disability - Not reported.</li> <li>• Long term health condition - Not reported.</li> <li>• Sexual orientation - Not reported.</li> <li>• Socioeconomic position - Living alone – Day hospital rehabilitation n=46 (40.7%). Home based rehabilitation n=45 (38.8%). No home services - Day hospital rehabilitation n=90 (79.6%). Home based rehabilitation n=96 (82.8%).</li> </ul> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers - Home based rehabilitation n=116 randomised; n=114 assessed at 3 month follow-up; n=112 assessed at 6 month follow-up.</li> </ul>	<p><b>Quality of life (mental) measured using the Short-Form-36 (SF-36):</b> Day hospital rehabilitation – baseline 47.1 (SD=10.9); 3 months 47.3 (SD=12.2); change -0.02 (SD=12.3). Home based rehabilitation - baseline 47.9 (SD=10.6); 3 months 46.7(SD = 12.4); change -1.4 (SD=11.4).</p> <p>Effect sizes for Quality of life (mental) measured using SF-36: Baseline: d=0.0744; 95% CI = -0.1847 to 0.3336; 3-months: d=-0.0488; 95% CI -0.3079 to 0.2103; Change: d=-0.1164; 95% CI -0.3757 to 0.1428.</p> <p>Between group differences in change in scores between baseline and 3 months – No significant difference.</p> <p><b>Quality of life (physical) measured using the Short-Form-36 (SF-36):</b> Day hospital rehabilitation – baseline 36.8 (SD=10.5); 3 months 42.6 (SD=10.2); change 5.9 (SD=9.5). Home based rehabilitation - baseline 36.2 (SD=9.8); 3 months 42.7 (SD=10.0); change 6.9 (SD=8.9).</p> <p>Effect sizes of Quality of life (physical) measured using the SF-36 measure: Baseline: d=-0.0591; 95% CI -0.3182 to 0.2;</p>	

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	<ul style="list-style-type: none"> <li>• Intervention numbers - Day hospital rehabilitation n=113 randomised; n=108 assessed at 3 month follow-up; n=106 assessed at 6 month follow-up.</li> <li>• Sample size - N=229 randomised; N=222 assessed at 3 month follow-up; N=218 assessed at 6 month follow-up.</li> </ul> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Day hospital based rehabilitation.</li> <li>• Describe intervention - A high-intensity rehabilitation programme based on a medical rehabilitation model delivered in a day hospital setting and an education session for carers.</li> <li>• Delivered by - Not reported, simply described as interdisciplinary.</li> <li>• Delivered to - Medically stable patients after discharge from acute care (the main reasons for admission were stroke, knee replacement, or 'other neurological injury').</li> </ul>	<p>3-months: d=0.0099; 95% CI -0.2492 to 0.269; Change: d=0.1087; 95% CI -0.1506 to 0.3679.</p> <p>Between group differences in change in scores between baseline and 3 months – No significant difference.</p> <p><b>Functional competence in activities of daily living (motor) measured using the Assessment of Motor and Process Skills:</b> Day hospital rehabilitation – baseline 0.40 (SD=0.8); 3 months 0.97 (SD=0.8); change 0.57 (SD=0.8). Home based rehabilitation - baseline 0.29 (SD=0.8); 3 months 0.91 (SD=0.8); change 0.62 (SD=0.8).</p> <p>Effect sizes of motor and process skills (motor score): Baseline: d=-0.1375; 95% CI -0.3969 to 0.1219; 3-month: d=-0.075; 95% CI -0.3341 to 0.1841; Change: d=0.0625; 95% CI -0.1966 to 0.3216.</p> <p>Between group differences in change in scores between baseline and 3 months – No significant difference.</p> <p><b>Functional competence in activities of daily living (process) measured using the Assessment of Motor and Process Skills:</b> Day hospital rehabilitation – baseline 0.54 (SD=0.6); 3 months 1.05 (SD=0.5); change</p>	

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	<ul style="list-style-type: none"> <li>• Duration, frequency, intensity, etc. - Three to 5 sessions per week lasting 3 hours. Although duration was not standardised the intervention was usually delivered for 4 to 6 weeks.</li> <li>• Key components and objectives of intervention - Individual or group rehabilitation sessions, multidisciplinary assessment and weekly case management meetings (including goal setting). The sessions included support from a rehabilitation medicine physician, dietetics, nursing support, occupational therapy, physiotherapy, psychology, social work, and speech therapy.</li> <li>• Content/session titles - N/A</li> <li>• Location/place of delivery - Day hospital.</li> </ul> <p><b>Comparison intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Home based rehabilitation. A high-intensity rehabilitation</li> </ul>	<p>0.51 (SD=0.5). Home based rehabilitation - baseline 0.46 (SD=0.6); 3 months 1.00 (SD=0.5); change 0.54 (SD=0.5).  Effect sizes in AMP (process) skills: Baseline: d=-0.1333; 95% CI -0.3927 to 0.126; 3 months: d=-0.1; 95% CI -0.3592 to 0.1592; Change: d=0.06; 95% CI -0.1991 to 0.3191.</p> <p>Between group differences in change in scores between baseline and 3 months – No significant difference.</p> <p><b>Functional independence measured using the Functional Independence Measure (FIM):</b> Day hospital rehabilitation – baseline 108.5 (SD=12.4); 3 months 118.1 (SD=8.1); change 9.6 (SD=9.0). Home based rehabilitation - baseline 108.1 (SD=8.4); 3 months 115.5 (SD=6.8); change 7.4 (SD=5.8).</p> <p>Effect sizes of FIM measures: Baseline: d= -0.0379; 95% CI -0.2969 to 0.2212; Discharge from programme: d=-0.3481; 95% CI = -0.6091 to -0.0871; Change: d=-0.2914; 95% CI -0.5518 to -0.00309</p> <p>Between group differences in scores at 3 months – Participants randomised to the day hospital rehabilitation programme had significantly higher scores on the Functional</p>	

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	<p>programme based on a medical rehabilitation model delivered in the participants own home.</p> <ul style="list-style-type: none"> <li>• Delivered by - Not reported, simply described as interdisciplinary. Delivered to - Medically stable patients after discharge from acute care (the main reasons for admission were stroke, knee replacement, or 'other neurological injury').</li> <li>• Duration, frequency, intensity, etc. - Three to 5 sessions per week (length of each session not reported). Although duration was not standardised the intervention was usually delivered for 4 to 6 weeks.</li> <li>• Key components and objectives of intervention – Individual rehabilitation sessions, multidisciplinary assessment and weekly case management meetings (including goal setting). The sessions included support from a rehabilitation medicine physician, dietetics, nursing support, occupational therapy, physiotherapy, psychology,</li> </ul>	<p>Independence Measure at 3 month follow-up than those randomised to the home based rehabilitation programme (p=0.01). Between group differences in change in scores between baseline and 3 months – Between baseline and 3 month follow-up, participants randomised to the day hospital rehabilitation programme made significantly greater improvements in scores on the Functional Independence Measure than those randomised to the home based rehabilitation programme (p=0.03). NB. In table 2 on p3 this measure is reported as being assessed at discharge, however in the authors' narrative they report this as being assessed at 3 month follow-up.</p> <p><b>Maximal quadriceps strength:</b> Day hospital rehabilitation – baseline 6.2 (SD=3.0); 3 months 10.9 (SD=5.8); change 4.7 (SD=5.0). Home based rehabilitation - baseline 6.5 (SD=3.5); 3 months 11.3 (SD= 5.4); change 4.8 (SD=4.5).</p> <p>Effect sizes of Maximal quadriceps strength measures: Baseline: d=0.0919; 95% CI -0.1673 to 0.3511; 3 month: d=0.0714; 95% CI -0.1877 to 0.3306; Change: d=0.021; 95% CI -0.238 to 0.2801.</p>	

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	<p>social work, and speech therapy.</p> <ul style="list-style-type: none"> <li>• Content/session titles – N/A.</li> <li>• Location/place of delivery – Participants own homes.</li> </ul> <p><b>Outcomes measured:</b> Service user related outcomes –</p> <ul style="list-style-type: none"> <li>• Mass.</li> <li>• Quality of life (mental and physical) measured using the Short-Form-36. Change in functional competence in activities of daily living (between baseline and 3 month follow-up) measured using the Assessment of Motor and Process Skills. Assessed by occupational therapist. Scores are given for both motor and process skills (ranging between -3 and 4).</li> <li>• Functional independence measured using the Functional Independence Measure.</li> <li>• Maximal quadriceps strength. Mobility measured using the Timed Up and Go test.</li> <li>• Mortality.</li> </ul>	<p>Between group differences in change in scores between baseline and 3 months – No significant difference.</p> <p><b>Mobility measured using the Timed Up and Go (TUG) test:</b> Day hospital rehabilitation – baseline 35.9 (SD=43.8); 3 months 18.7 (SD=13.2); change -17.2 (SD=39.9). Home based rehabilitation - baseline 32.4 (SD=23.0); 3 months 23.2 (SD=28.1); change -11.4 (SD=23.0).</p> <p>Effect sizes in TUG test measures: Baseline: <math>d=-0.1003</math>; 95% CI -0.3596 to 0.1589; 3 months: <math>d=0.2041</math>; 95% CI -0.0556 to 0.4639; Change: <math>d=0.1787</math>; 95% CI -0.0809 to 0.4383. Between group differences in change in scores between baseline and 3 months – No significant difference.</p> <p><b>Mortality:</b> At 3 months follow-up there had been no deaths. At 6 months, 4 participants had died however between group differences and their statistical significance are not reported.</p> <p><b>Carer related outcomes - Strain measured using the Carer Strain Index (CS):</b> Day hospital rehabilitation – discharge 4.95 (SD=4.1); 3 months 4.92</p>	

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	<p>Family or caregiver related outcomes –</p> <ul style="list-style-type: none"> <li>• Strain measured using the Carer Strain Index.</li> <li>• Quality of life (mental and physical) measured using the Short-Form-36.</li> </ul> <p>Service outcomes –</p> <ul style="list-style-type: none"> <li>• Number of readmissions.</li> <li>• Time to first readmission.</li> <li>• Place of residence.</li> </ul> <p><b>Follow-up:</b> Three months and 6 months (the majority of outcomes are only measured at 3 months).</p> <p><b>Costs?</b> No. Costs or resource use information is not provided.</p>	<p>(SD=3.86); change – not measured. Home based rehabilitation – discharge 3.56 (SD=2.76); 3 months 4.25 (SD=3.10); change – not measured.</p> <p>Effect sizes of CS measures: Baseline: <math>d=-0.3987</math>; 95% CI -0.6603 to -0.1371; 3 months: <math>d=-0.1917</math>; 95% CI -0.4513 to 0.068; Change scores reported as ‘not applicable’.</p> <p>Between group differences in scores at discharge from programme – Carers of participants randomised to the day hospital programme reported significantly higher Carer Strain Index scores at discharge than those randomised to the home based rehabilitation programme (<math>p&lt;0.05</math>). Between group differences in scores at 3 month follow-up - No significant difference.</p> <p><b>Carer Quality of life (physical) measured using the Short-Form-36(SF-36):</b> Day hospital rehabilitation – baseline 52.67 (SD=10.36); 3 months 52.16 (SD=9.36); change -0.052 (SD=9.07). Home based rehabilitation - baseline 52.42 (SD=9.31); 3 months 50.94 (SD=9.40); change -1.48 (SD=5.29).</p> <p>Effect sizes of carer quality of life measured using SF-36: Baseline: <math>d=-0.0254</math>; 95% CI -0.2845 to 0.2337; 3 months: <math>d=-0.1301</math>; 95%</p>	

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		<p>CI -0.3894 to 0.1293; Change: d=-0.1297; 95% CI -0.3891 to 0.1296.</p> <p>Between group differences in change in scores between baseline and 3 months – No significant difference (statistical data not presented).</p> <p>Significance of between group differences in scores is not reported.</p> <p><b>Quality of life (mental) measured using the Short-Form-36 (SF-36):</b> Day hospital rehabilitation – baseline 44.65 (SD=11.81); 3 months 44.47 (SD=10.09); change -0.18 (SD=8.86). Home based rehabilitation - baseline 45.59 (SD=10.47); 3 months 44.69 (SD=11.08); change -0.90 (SD=8.71).</p> <p>Effect sizes of impact on carer’s quality of life measured using SF-36: Baseline: d=0.0843; 95% CI -0.1749 to 0.3435; 3 month: d=0.0207; 95% CI -0.2383 to 0.2798; Change: d=0.082; 95% CI -0.1772 to 0.3411.</p> <p>Between group differences in change in scores between baseline and 3 months – No significant difference (statistical data not presented).</p> <p>Significance of between group differences in scores is not reported.</p> <p><b>Service outcomes –</b></p>	

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		<p><b>Number of readmissions:</b> Day hospital rehabilitation – Participants randomised to day hospital rehabilitation were significantly more likely than those randomised to the home based programme to be readmitted to hospital – relative risk ratio 2.1 (95% CI 1.2 to 3.9; <math>p=0.012</math>). 82.9% of readmissions in the day hospital rehabilitation group and 67.7% in the home based rehabilitation programme were considered to be probably/possibly related to the index admission.</p> <p><b>Time to first readmission:</b> Day hospital rehabilitation – Median time to first readmission was 25 days (95% CI 17.3 to 34.0). Home based rehabilitation - Median time to first readmission was 49 days (95% CI 25.3 to 54.3). Between group difference in median time to first readmission: There was a significant difference between groups, with participants randomised to the day hospital rehabilitation group being readmitted more quickly than those randomised to the home based rehabilitation programme (<math>p=0.050</math>).</p> <p>The authors report narratively that there was no significant interaction between ‘... the groups and age group, gender, marital status or carer status with respect to time to first</p>	

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		<p>readmission' (p632). Statistical data not presented.</p> <p><b>Place of residence:</b> At 3 months 8 participants had moved into residential care permanently; at 6 months 5 other participants had moved into permanent residential placements however between group differences and their statistical significance are not reported.</p> <p><b>Narrative findings – effectiveness:</b> NB. Effect sizes are not presented.</p> <p><b>Service user related outcomes –</b></p> <p><b>Mass:</b> Significance of between group differences in mass at 3 months follow-up and change in mass between baseline and 3 months follow-up are not reported.</p> <p><b>Quality of life (mental) measured using the Short-Form-36:</b> Between group difference in change in scores between baseline and 3 months – No significant difference. Significance of between group differences in scores at 3 months follow-up is not reported.</p>	

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		<p><b>Quality of life (physical) measured using the Short-Form-36:</b> Between group differences in change in scores between baseline and 3 months – No significant difference. Significance of between group differences in scores at 3 months follow-up is not reported.</p> <p><b>Functional competence in activities of daily living (motor) measured using the Assessment of Motor and Process Skills:</b> Between group differences in change in scores between baseline and 3 months – No significant difference (statistical data not presented). Significance of between group differences in scores at 3 months follow-up is not reported.</p> <p><b>Functional competence in activities of daily living (process) measured using the Assessment of Motor and Process Skills:</b> Between group differences in change in scores between baseline and 3 months – No significant difference (statistical data not presented). Significance of between group differences in scores at 3 months follow-up is not reported.</p> <p><b>Functional independence measured using the Functional Independence Measure:</b></p>	

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		<p>Between group differences in scores at 3 months – Participants randomised to the day hospital rehabilitation programme had significantly higher scores on the Functional Independence Measure at 3 month follow-up than those randomised to the home based rehabilitation programme.</p> <p>Between group differences in change in scores between baseline and 3 months – Between baseline and 3 month follow-up, participants randomised to the day hospital rehabilitation programme made significantly greater improvements in scores on the Functional Independence Measure than those randomised to the home based rehabilitation programme.</p> <p><b>Maximal quadriceps strength:</b> Between group differences in change in scores between baseline and 3 months – No significant difference (statistical data not presented). Significance of between group differences in scores at 3 months follow-up is not reported.</p> <p><b>Mobility measured using the Timed Up and Go test:</b> Between group differences in change in scores between baseline and 3 months – No significant difference (statistical data not presented). Significance of between</p>	

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		<p>group differences in scores at 3 months follow-up is not reported.</p> <p><b>Carer related outcomes –</b></p> <p><b>Strain measured using the Carer Strain Index:</b> Between group differences in scores at discharge from programme – Carers of participants randomised to the day hospital programme reported significantly higher Carer Strain Index scores at discharge than those randomised to the home based rehabilitation programme.</p> <p>Between group differences in scores at 3 month follow-up - No significant difference (statistical data not presented). Significance of between group differences in scores at 3 months follow-up is not reported.</p> <p><b>Quality of life (physical) measured using the Short-Form-36:</b> Between group differences in change in scores between baseline and 3 months – No significant difference (statistical data not presented). Significance of between group differences in scores at 3 months follow-up is not reported.</p> <p><b>Quality of life (mental) measured using the Short-Form-36:</b> Between group differences in change in scores between baseline and 3</p>	

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		<p>months – No significant difference (statistical data not presented). Significance of between group differences in scores at 3 months follow-up is not reported.</p> <p><b>Service outcomes -</b> <b>Number of readmissions:</b> Participants randomised to day hospital rehabilitation were significantly more likely than those randomised to the home based programme to be readmitted to hospital.</p> <p><b>Time to first readmission:</b> Between group differences in median time to first readmission - There was a significant difference between groups, with participants randomised to the day hospital rehabilitation group being readmitted more quickly than those randomised to the home based rehabilitation programme.</p> <p>The authors report narratively that there was no significant interaction between ‘... the groups and age group, gender, marital status or carer status with respect to time to first readmission’ (p632).</p> <p><b>Place of residence:</b> At 3 months 8 participants had moved into residential care permanently; at 6 months 5 other participants</p>	

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		had moved into permanent residential placements however between group differences are not reported. Mortality: At 3 months follow-up there had been no deaths. At 6 months, 4 participants had died but between group differences are not reported.	

**2. Jackson JC, Ely EW, Morey MC et al. (2012) Cognitive and physical rehabilitation of intensive care unit survivors: Results of the RETURN randomized controlled pilot investigation. Critical Care Medicine 40(4): 1088-97**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<b>Study aim:</b> To test the following hypothesis: in a cohort of ICU survivors, a 'bundled' rehabilitation approach combining cognitive, physical, and functional rehabilitation could be developed and effectively delivered in the home using novel tele-video technology delivered via social workers and would result in greater improvement in cognition and	<p><b>Participants:</b> Service users and their families, partners and carers - ICU survivors.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Control: median 50 (46-69) Intervention: median 47 (41-63) Complete intervention patient: median 44 (41-63).</li> <li>• Sex - Control: f, 62% (n=5) m, 38% (n=3); Intervention: f, 38% (n=5) m, 62% (n=8); Complete intervention patient: f, 71% (n=5) m, 29% (2).</li> <li>• Ethnicity - Control: White, 88% (n=7) African-American, 12% (n=1) Intervention: White, 92% (n=12) African-American, 8%</li> </ul>	<p><b>Findings - effect sizes:</b> NB. Effect sizes not provided. Findings presented are median with p values.</p> <p><b>Cognitive function (TOWER):</b> Intervention and control group participants performed similarly at study enrolment on the primary cognitive outcome measure. Baseline - Control, 7.5 (4.5 - 9) - Intervention, 8.0 (6.5 - 10) p value 0.37 (not sig). At 3-month follow-up (intervention group patients earning higher scores than controls): - Control, 7.5 (4.0 to 8.50) - Intervention, 13.0 (11.5 to 14.0) p value &lt;0.01 (sig) NB: The adjusted treatment effect (adjusted for baseline differences) is 5.0 (95% CI 2.5 to 7.5) adjusted p&lt;0.01.</p> <p><b>Secondary measures of cognition - DEX:</b></p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

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<p>functional outcomes in intervention than control participants.</p> <p><b>Methodology:</b> RCT. This was a single-site, feasibility, pilot, randomized trial.</p> <p><b>Country:</b> United States.</p> <p><b>Source of funding:</b> Government – Funded in part by the National Institutes of Health.</p>	<p>(n=1) Complete intervention patient: White, 86% (6) African-American, 14% (n=1).</p> <ul style="list-style-type: none"> <li>Long term health condition - Not necessarily long term but the admission diagnosis: Control Intervention Complete intervention patient</li> </ul> <p>Sepsis/ARDS1 25% (2) 31% (4) 29% (2) Acute MI2 0% (0) 8% (1) 14% (11) COPD/Asthma3 0% (0) 8% (1) 0% (0) Renal Failure 0% (0) 8% (1) 0% (0) Airway Protection 0% (0) 8% (1) 14% (1) Cardiogenic Shock/ CHF4 12% (1) 15% (2) 14% (1) Cirrhosis 12% (1) 8% (1) 14% (1) ENT Surgery 12% (1) 0% (0) 0% (0) Transplants (excl Liver) 12% (1) 0% (0) 0% (0) Hepatobiliary Surgery 12% (1) 15% (2) 14% (1) Pulmonary 12% (1) 0% (0) 0% (0).</p> <p><b>Sample size -</b></p> <ul style="list-style-type: none"> <li>Comparison numbers: n=8.</li> <li>Intervention numbers: 13 (but complete intervention patients n=7).</li> </ul>	<p>Baseline: Both groups performed similarly to one another) Control, 27.0 (13.5- 31.0) - Intervention, 13.0 (8.0- 15.0) p value 0.12 (not sig).</p> <p>3 month: - Control, 16.0 (7.8-19.2) - Intervention, 8.0 (6.0- 13.5) p value 0.74 (not sig).</p> <p><b>MMSE:</b> baseline - Control, 27.0 (22.5- 28.2) - Intervention, 28.0 (25.0- 29.0) p value 0.54 3 month MMSE - Control, 26.5 (24.8-28.5) - Intervention, 30.0 (29.0-30.0) p value 0.25 (not sig).</p> <p><b>Physical functioning – TUG</b> (low is good) - Baseline - Control, 15 (12- 20) - Intervention, 18 (15-20) p value 0.47; 3 month TUG - Control, 10.2 (9.2 -11.7) - Intervention, 9.0 (8.5-11.8) p value 0.51 NOTE: the adjusted effect size (adjusted for baseline differences) is -1.1 (95% CI -4.1 to 2.0); adjusted p=0.51).</p> <p><b>ABC</b> (high score is good): Baseline - Control, 54 (28- 75) - Intervention, 68 (36-81) p value 0.58; 3 months ABC - Control, 83 (38- 91) - Intervention, 82 (78- 89) p value 0.35 3.</p> <p><b>Functional ability IADL</b> (functional activities questionnaire - higher score is poorer performance): baseline - Control, 7.0 (1.5-</p>	

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	<p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>Describe intervention - Three pronged RETURN intervention. Comprehensive, multicomponent, in-home rehabilitation program which was developed with a specific focus on the remediation of characteristic deficits among ICU survivors (i.e., limitations in cognition, strength and endurance and functional ability). The rehabilitation intervention was provided over a 12-week period post-discharge in each patient's home and integrated both traditional 'face-to-face' interventions as well as novel telephonic and video-based interventions. Total of 12 visits - 6 in-person visits for cognitive rehabilitation and 6 televisits for physical and functional rehabilitation, (60-75 minutes in length), with sessions following an alternating format (i.e. first cognitive then physical-functional and so on). Televisits used interactive 2-way</li> </ul>	<p>14.2) - Intervention, 0.0 (0.0-4.0) p value 0.14; 3 month IADL - Control, 8.0 [6.0- 11.8] - Intervention, 1.0 [0.0 - 2.5] p value 0.04 NOTE: the adjusted treatment effect (adjusted for baseline differences) is -4.7 (95% CI -8.7 to -0.6)</p> <p><b>ADL:</b> baseline The group with little/ no dependency - Control, 75% (6) - Intervention, 71% (5) The group with moderate/ severe dependency - Control, 25% (2) - Intervention, 29% (2) 3 month ADL The group with little/ no dependency - Control, 75% (6) - Intervention, 100% (7) The group with moderate/ severe dependency - Control, 25% (2) - Intervention, 0% (0) NOTE: adjusted treatment effect p=0.78</p> <p><b>Narrative findings – effectiveness:</b></p> <p><b>Cognitive function outcomes:</b> Intervention and control group participants performed similarly at study enrolment on the primary cognitive outcome measure, the TOWER. At 3-month follow-up, a significant difference between groups was observed, with the intervention group patients earning higher scores than controls (3-months TOWER - Median/IQR - 13.0 [11.5 to 14.0] vs. 7.5 [4.0</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>videophones facilitated by an assistant in the home and/or were video recorded for subsequent review. Visits were supplemented with brief telephone calls by study personnel from relevant disciplines during alternate weeks. Participants completed a workbook between visits to help track compliance.</p> <ul style="list-style-type: none"> <li>Delivered by - Cognitive rehabilitation - a master's level psychology technician who was supervised by a licensed neuropsychologist. Physical rehabilitation - a remote bachelor's level exercise trainer supervised by a doctoral level exercise physiologist who was communicating in "real time" with the patient via teletechnology and assistance of a trained social worker in the home. Functional rehabilitation - occupational therapist who was communicating in "real time" with the patient via teletechnology and with the</li> </ul>	<p>to 8.5], adjusted treatment effect 5.0 [95% CI 2.5 to 7.5], adjusted p&lt;0.01).</p> <p><b>Secondary measures of cognition:</b> Both groups performed similarly to one another on the DEX and the MMSE at baseline and 3-month follow-up.</p> <p><b>Physical functioning:</b> On the TUG (lower scores are better), intervention and control participants earned similar scores at baseline (prior to intervention) (18 [15-20] vs. 15 [12-20]) and at 3-months (9.0 [8.5 vs. 11.8] vs. 10.2 [9.2-11.7]). Although the intervention group improved slightly more than the control group these differences were not statistically significance adjusted treatment effect -1.1 [95% CI-4.1 to 2.0], adjusted p=0.51).</p> <p><b>ABC:</b> Scores of self-efficacy did not differ between the 2 groups at baseline (68 [36-81] vs. 54 [28-75], p=0.58) nor at 3-months (82 [78-89] vs. 83 [38-91], p=0.35)</p> <p><b>Functional ability – IADL:</b> No statistically significant differences were noted in baseline IADL performance (prior to intervention) between intervention and control group participants. At 3-month follow-up, a statistically significant difference was</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>assistance of a trained social worker in the home.</p> <ul style="list-style-type: none"> <li>• Delivered to - ICU patients on discharge from hospital.</li> <li>• Duration, frequency, intensity, etc. - 12 week period post discharge. A total of 12 visits - 6 in- person visits for cognitive rehabilitation and 6 televisits for physical and functional rehabilitation, each 60-75 minutes in length, with sessions following an alternating format (i.e., first cognitive then physical-functional and so on).</li> <li>• Key components and objectives of intervention - 1. Cognitive rehab - based on the Goal Management Training (GMT) protocol, a focused and theoretically derived stepwise approach to the rehabilitation of executive function shown to be effective in preliminary studies with other populations, which the researchers adapted for use in the home. Purpose of GMT - to improve a patient's executive function by increasing goal directed behaviour and helping</li> </ul>	<p>observed between groups, with intervention participants demonstrating better IADL performance vs. controls (lower scores are better) (3-month FAQ 1.0 [0.0 – 2.5] vs. 8.0 [6.0 – 11.8], p=0.04), supported by an ANCOVA analyses showing an adjusted treatment effect of -4.7 (95% CI -8.7 to -0.6).</p> <p><b>Functional ability – ADL:</b> With regard to ADLs, scores on the Katz ADL scale dichotomized into categories ‘little or no dependency’ and ‘moderate to severe dependency’ were similar between groups at enrolment (29% of intervention participants with ‘moderate to severe dependency’ vs. 25% of controls, p=0.88). At 3-month follow-up, none of the intervention participants reported experiencing ‘moderate to severe dependency,’ while ‘moderate to severe dependency’ was reported by a quarter (25%) of those in the control group, though after adjusting for baseline values, these differences were not statistically significant (adjusted p=0.78).</p> <p><b>Conclusion:</b> Using social workers/technicians and telemedicine to deliver a 3-pronged rehabilitation program to general medical and surgical ICU survivors in their homes resulted in superior executive functioning as compared</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>patients (a) learn to be reflective and (b) achieve success in engaging complex tasks by dividing them into manageable units, so as to increase the likelihood that these tasks will be completed.</p> <p>2. Physical Rehabilitation - Included 6 televideo visits (one every other week) and 6 motivational telephone calls. Each call followed a structured protocol to assess previously prescribed exercises, explore and address potential barriers to exercise, motivate and encourage continued exercise and advance previous exercises as needed. In between visits and calls, the patients carried out exercises independently.</p> <p>3. Functional Rehabilitation - 4 televisits with an OT who was communicating in 'real time' with the patient via teletechnology and assistance of a trained social worker in the home, 4-6 supplementary telephone calls, and participant homework between sessions.</p>	<p>to usual care in this small pilot feasibility randomized trial. Intervention group participants also reported improvements in the performance of daily IADLs (managing money, making travel arrangements, following complex instructions, etc.). The benefits found via this rehabilitation program together with the novel components of delivery (in-home using social workers and technicians as well as telemedicine), can serve as a template by which to pave a road to future investigations and eventually a change in policy and practice towards survivors of critical care.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>Two tactics were used for the functional training: (a) Education – helping the participant understand the relationship between ‘person’, ‘environment’, and ‘activity’. (b) ‘Action Plan’ Development – utilized for individual tasks, based on a combination of the therapist input and participant homework. Homework focused on specific tasks prioritized by the study participant, with worksheets designed to foster problem-solving using the ‘Person-Environment-Activity’ approach and application of the principles taught in the cognitive training and the physical skills developed through the exercise training to the prioritized activities.</p> <p>Location/place of delivery - In the home including remotely via two way interaction televisits supported by an in home assistant.</p> <p><b>Comparison intervention</b> - The scope of ‘usual care’ interventions</p>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>employed with ICU survivors may include physical therapy (PT), occupational therapy (OT), and nursing care, delivered to in-patient, out-patient, or home-health settings. Neither cognitive therapy nor speech therapy with a predominant cognitive focus is considered “usual care” among ICU survivors without frank neurologic injuries.</p> <p><b>Outcomes measured:</b>  <u>Service user related outcomes –</u></p> <ul style="list-style-type: none"> <li>• Cognitive function - primary cognitive outcome measure was TOWER). Physical functioning - TUG (timed up and go test).</li> <li>• Functional ability - IADL and ADL (Katz ADL scale).</li> </ul> <p><b>Costs? No.</b></p>		

**3. Mahomed NN, Davis AM, Hawker G et al. (2008) Inpatient compared with home-based rehabilitation following primary unilateral total hip or knee replacement: A randomized controlled trial. American Journal of Bone and Joint Surgery 90A(8): 1673-80**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The aim of the study was to evaluate the effectiveness and cost of home based, compared with inpatient, rehabilitation following primary total hip or knee joint replacement.</p> <p><b>Methodology:</b> RCT. Participants were randomly allocated to either home based compared or inpatient rehabilitation.</p> <p><b>Country:</b> Canada.</p> <p><b>Source of funding:</b> Other - The authors received outside funding or grants</p>	<p><b>Participants:</b> Service users and their families, partners and carers - The study sample consisted of participants who were undergoing unilateral hip or knee replacement for osteoarthritis, inflammatory arthritis, or osteonecrosis, and therefore using intermediate care services.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - The mean age of participants was 68 years.</li> <li>• Sex - Approximately two-thirds of participants were women (the exact number is not provided).</li> <li>• Ethnicity - Approximately two-thirds of participants were White (the exact number is not provided).</li> <li>• Religion/belief – Not reported.</li> <li>• Disability - Not reported.</li> <li>• Long term health condition - Participants were undergoing</li> </ul>	<p><b>Findings - effect sizes:</b> NB. Means and standard deviation for SF-36 scores were presented in the report, but not effect sizes, which were calculated by the review team.</p> <p><b>Pre-operative scores -</b></p> <p><b>Physical function:</b> Home based (M=26, SD=20) Inpatient (M=26, SD=21) p=0.93.</p> <p><b>Physical component summary:</b> Home based (M=29, SD=7) Inpatient (M=27, SD=7) p = 0.13.</p> <p><b>Mental component summary:</b> Home based (M=43, SD=11) Inpatient (M=45, SD=10) p=0.15.</p> <p><b>Three month follow-up -</b></p> <p><b>Physical function:</b> Home based (M=47, SD=25) Inpatient (M=49, SD=24) p=0.25.</p> <p><b>Physical component summary:</b> Home based (M=34, SD=9) Inpatient (M=36, SD=10) p=0.11.</p> <p><b>Mental component summary:</b> Home based (M=44, SD=10) Inpatient (M=45, SD=11) p=0.83.</p> <p><b>Satisfaction:</b> Home based (M=87, SD=15) Inpatient (M=89, SD=14) p=0.37.</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>from Physicians' Services Incorporated.</p>	<p>unilateral hip or knee replacement for osteoarthritis, inflammatory arthritis, or osteonecrosis.</p> <ul style="list-style-type: none"> <li>• Sexual orientation - Not reported.</li> <li>• Socioeconomic position - Approximately 50% of participants had postsecondary education (the exact number is not provided).</li> </ul> <p><b>Sample size –</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers: n=119 (inpatient group), based on ITT analysis. The actual number that received the intervention was 95.</li> <li>• Intervention numbers: n=115 (home based rehabilitation group), based on ITT analysis. The actual number that received the intervention was 139 (due to crossover patients).</li> <li>• Sample size: n=234.</li> </ul> <p><b>Intervention:</b></p>	<p><b>12 month follow-up -</b></p> <p><b>Physical function:</b> Home based (M=57, SD=28) Inpatient (M=50, SD=27) p=0.11.</p> <p><b>Physical component summary:</b> Home based (M=34, SD=9) Inpatient (M=39, SD=12) p=0.99.</p> <p><b>Mental component summary:</b> Home based (M=45, SD=9) Inpatient (M=44, SD=10) p=0.80.</p> <p><b>Satisfaction:</b> Home based (M=90, SD=14) Inpatient (M=90, SD=15) p=0.94.</p> <p><b>Effect sizes:</b> Comparison 3 months after total joint replacement, using WOMAC (Western Ontario and McMaster Universities Osteoarthritis Index): Pain: d=0; 95% Confidence Interval (CI) -0.2563 to 0.2563; Stiffness: d=0.1; 95% CI -0.1565 to 0.3565; Physical function: d=0.0526; 95% CI -0.2037 to 0.309. Physical function: d=-0.0816; 95% CI -0.338 to 0.1748; Physical component summary: d=-0.21; 95% CI -0.467 to 0.047; Mental component summary: d=-0.0951; 95% CI -0.3515 to 0.1614; Satisfaction score: d=-0.1379; 95% CI -0.3945 to 0.1187. Twelve months after total joint replacement WOMAC: Pain: d=0.2204; 95% CI -0.0366 to 0.4775; Stiffness: d=0.1944; 95% CI</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Intervention category - The intervention was home based rehabilitation.</li> <li>• Describe intervention - Those allocated to home based rehabilitation were referred to their Community Care Access Centre and managed along a multidisciplinary pathway that ensured that each participant was seen at home by a physiotherapist within 48 hours of discharge.</li> <li>• Delivered by - Participants were referred to their Community Care Access Centre and managed along a multidisciplinary pathway.</li> <li>• Delivered to - The intervention was delivered to participants who were undergoing unilateral hip or knee replacement for osteoarthritis, inflammatory arthritis, or osteonecrosis.</li> <li>• Duration, frequency, intensity, etc. - Not reported.</li> <li>• Key components and objectives of intervention - It is noted that the overall objective of home</li> </ul>	<p>-0.0625 to 0.4513; Physical function: d=0.2105; 95% CI -0.0465 to 0.4675.  Twelve months after total joint replacement  Short Form-36: Physical function: d=0.2546; 95% CI -0.0027 to 0.5119; Physical component summary: d=0.0869; 95% CI -0.1695 to 0.3434; Mental component summary: d=0.105; 95% CI -0.1514 to 0.3615; Satisfaction score: d=0; 95% CI -0.2563 to 0.2563.  Cost comparison (in 2006 Canadian dollars):  Acute hospital costs: d=0.0948; 95% CI -0.1617 to 0.3512; Rehabilitation costs: d=-0.7769; 95% CI -1.0427 to -0.5111; Total episode-of-care costs: d=-0.3495; 95% CI -0.6077 to -0.0912.</p> <p><b>Narrative findings – effectiveness:</b> There were no differences in clinical outcomes at 3 and 12 months after surgery, with both groups achieving similar improvements in pain and function.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>based rehabilitation is to reduce health care costs, without resulting in adverse patient outcomes.</p> <ul style="list-style-type: none"> <li>• Content/session titles - Not reported.</li> <li>• Location/place of delivery - The intervention was delivered in participants' homes.</li> <li>• Describe comparison intervention - Those allocated to the inpatient rehabilitation group were transferred to 1 of 2 independent institutions depending on the availability of rehabilitation beds. Participants were managed along previously established care pathways, with a target of a fourteen-day length of stay. No further details regarding the nature of the intervention are provided.</li> </ul> <p><b>Outcomes measured:</b>  <u>Service user related outcomes</u> -  The condition of participants with osteoarthritis of the knee and hip was measured using the Western Ontario and McMaster</p>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>Universities Arthritis Index (WOMAC; Bellamy et al. 1988). Health status was measured using the Short Form-36 (SF-36; Ware et al. 1993).</p> <p><u>Satisfaction with services</u> - Patient satisfaction was assessed using the Hip and Knee Satisfaction Scale (Mahomed et al. 1998).</p> <p><b>Follow-up:</b> Participants were assessed at baseline, 3 and 12 months.</p> <p><b>Costs?</b> Economic evaluation - full or partial. Direct health care costs were evaluated for acute care hospitals, inpatient rehabilitation hospitals, and home based rehabilitation services. These were calculated by multiplying per diem costs from the respective institutions with the actual length of stay for each patient. Patient-level costs for services provided by home care were obtained using the centralised data system.</p>		

**4. Parker SG, Oliver P, Pennington M et al. (2009) Rehabilitation of older patients: Day hospital compared with rehabilitation at home. A randomised controlled trial. Health Technology Assessment 13(39): DOI 10.3310/hta13390**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Aim of the study (write in):</b> The study aimed to test the hypothesis that ‘... older people and their informal carers are not disadvantaged by home-based rehabilitation relative to day hospital rehabilitation’ (piii).</p> <p><b>Methodology:</b> RCT. Participants randomised to either home based or day hospital based multidisciplinary rehabilitation. This paper also includes a literature review of studies of day hospital services for older people (some of which include home based care/rehabilitation as</p>	<p><b>Participants:</b> Service users and their families, partners and carers.</p> <ul style="list-style-type: none"> <li>• Service users - Individuals of any age referred for multidisciplinary services with a permanent address within the service’s catchment area. Reasons for referral included stroke, falls and mobility assessment, and orthopaedic rehabilitation.</li> <li>• Carers - Some participants had informal carers, the majority of whom were related to the service user.</li> </ul> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Mean age of service user (in years) at first interview (SD; min-max) - Control 76 (11; 53-95). Intervention 74 (11; 43-88). 65 years or younger (%) - Control 19.0. Intervention 21.4. 66-74 years (%) - Control 14.3. Intervention 19.0. 75-84 years (%) - Control 42.9. Intervention</li> </ul>	<p><b>Findings - effect sizes:</b> Service user related outcomes –</p> <p><b>Three months follow-up (observed case data set) –</b> <b>Activities of daily living measured using the Nottingham Extended Activities of Daily Living Scale (total score):</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) -2.79; 95% Confidence Interval -7.84 to 1.90; p=0.228.</p> <p><b>Anxiety measured using the Hospital Anxiety and Depression Scale:</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) 0.047; 95% CI -1.466 to 1.559; p=0.951.</p> <p><b>Depression measured using the Hospital Anxiety and Depression Scale:</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) 1.374; 95% CI -0.039 to 2.786; p=0.056.</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p>The failure to carry out 12 month follow-up assessments for some participants, high rate of attrition and lack of sufficient power mean that it is not possible to award a higher score.</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>a comparison) however this data has not been extracted as all included studies were published before 2005 (the publication date specified in the NCCSC review protocol.</p> <p><b>Country</b> - United Kingdom. Four services across England (Chippenham, North Tyneside, Newcastle upon Tyne, Barnsley).</p> <p><b>Source of funding:</b> Government - Health Technology Assessment programme.</p>	<p>45.2. 85 years or older (%) - Control 23.8. Intervention 14.3. Mean age of carer (in years) at first interview (SD; min-max) - Control 64 (12.67; 39-93). Intervention 64 (10; 43-86).</p> <ul style="list-style-type: none"> <li>• Sex - Service user - Female (%) - Control 45.2. Intervention 45.2. Carer - Female (%) - Control 60.9. Intervention 82.6.</li> <li>• Ethnicity - Not reported for service users or their carers.</li> <li>• Religion/belief - Not reported for service users or their carers.</li> <li>• Disability - Not reported for service users or their carers.</li> <li>• Long term health condition - Not reported for service users or their carers.</li> <li>• Sexual orientation - Not reported for service users or their carers.</li> <li>• Socioeconomic position - Not reported for service users or their carers. Carer relationship to service user (%): Spouse – control = 61. Intervention = 48. Child - control = 22.</li> </ul>	<p><b>Health related quality of life measured using the EUROQUOL 5 dimensions (questionnaire):</b> Significant difference between groups in favour of the control - mean estimated difference (adjusted for baseline scores) 0.122; 95% CI –0.002 to 0.242; p=0.047.</p> <p><b>Health related quality of life measured using the EUROQUOL 5 dimensions (visual analogue scale):</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) - 2.559; 95% CI –9.371 to 4.254; p=0.456.</p> <p><b>Six months follow-up (observed case data set) –</b></p> <p><b>Activities of daily living measured using the Nottingham Extended Activities of Daily Living Scale (total score):</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) -2.139; 95% CI -6.870 to 2.592; p=0.370.</p> <p><b>Activities of daily living measured using the Nottingham Extended Activities of Daily Living mobility subscale:</b> No significant difference between groups - mean</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>Intervention = 22. Friend - control = 9. Intervention = 17. Other - control = 9. Intervention = 13.</p> <p><b>Sample size –</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers: Randomised n=42 service users; received intervention n=42; analysed at 3 months n=35; analysed at 6 months n=33; analysed at 12 months n=17. The number of carers who participated is unclear although it appears that there were 23 in each group (it is not clear if any of these were lost to follow-up).</li> <li>• Intervention numbers: Randomised n=47 service users; received intervention n=42; analysed at 3 months n=37; analysed at 6 months n=32; analysed at 12 months n=26. The number of carers who participated is unclear although it appears that there were 23 in each group (it is not clear if any of these were lost to follow-up).</li> </ul>	<p>estimated difference (adjusted for baseline scores) -0.58; 95% CI -2.59 to 1.42; p=0.564.</p> <p><b>Activities of daily living measured using the Nottingham Extended Activities of Daily Living kitchen subscale:</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) -0.40; 95% CI -1.90 to 1.11; p=0.601.</p> <p><b>Activities of daily living measured using the Nottingham Extended Activities of Daily Living domestic subscale:</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) -0.91; 95% CI -2.31 to 0.49; p=0.198.</p> <p><b>Activities of daily living measured using the Nottingham Extended Activities of Daily Living leisure subscale:</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) -0.11; 95% CI -1.41 to 1.20; p=0.872.</p> <p><b>Household activities of daily living measured using the Nottingham Extended Activities of Daily Living domestic and kitchen subscales (composite):</b> No significant difference between groups - mean</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Sample size: Randomised n=89; received intervention n=44; analysed at 3 months n=72; analysed at 6 months n=65; analysed at 12 months n=43. The number of carers who participated is unclear although it appears that there were 23 in each group (it is not clear if any of these were lost to follow-up).</li> </ul> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Home based multidisciplinary rehabilitation.</li> <li>• Describe intervention – Not reported in detail. The authors state these services usually involved input from at least occupational therapy and physiotherapy in the participant’s own home.</li> <li>• Delivered by – The authors describe the services as multidisciplinary. North Tyneside: Services staffed by occupational therapists, physiotherapists,</li> </ul>	<p>estimated difference (adjusted for baseline scores) -1.38; 95% CI -3.88 to 1.12; p=0.273.</p> <p><b>Anxiety measured using the Hospital Anxiety and Depression Scale:</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) -0.578; 95% CI -2.409 to 1.253; p=0.530.</p> <p><b>Depression measured using the Hospital Anxiety and Depression Scale:</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) 1.033; 95% CI -0.441 to 2.507; p=0.166.</p> <p><b>Health related quality of life measured using the EUROQUOL 5 dimensions (questionnaire):</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) 0.023; 95% CI -0.114 to 0.161; p=0.735.</p> <p><b>Health related quality of life measured using the EUROQUOL 5 dimensions (visual analogue scale):</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) - 1.601; 95% CI -8.809 to 5.607; p=0.659.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>social workers, assistants, administrative staff and 'other'. Chippenham: Services staffed by occupational therapists, physiotherapists, assistants, and administrative staff. Newcastle upon Tyne: Services staffed by 'other form of nurse' (as opposed to community nurses, acute hospital nurses or community hospital nurses), a hospital doctor, occupational therapists, physiotherapists, social workers, assistants, administrative staff, and 'other'. Barnsley: Services staffed by physiotherapists only but the authors note that '... in practice the physiotherapists work closely with colleagues from multiple disciplines to meet assessed needs for individual patients' (p23).</p> <ul style="list-style-type: none"> <li>Delivered to – Older people referred for multi-disciplinary rehabilitation. The services could be specialised (e.g. stroke specific) or be provided</li> </ul>	<p><b>Proportion of participants classifying themselves as having experienced a problem in 1 of the five domains of health related quality of life measured using the EUROQUOL 5 dimensions (adjusted for baseline proportions) at six months:</b></p> <p><b>Mobility</b> – No significant difference between groups - adjusted odds ratio 1.16; 95% CI 0.24 to 5.51; p=0.852. <b>Usual activities</b> – No significant difference between groups - adjusted odds ratio 0.33; 95% CI 0.09 to 1.23; p=0.100.</p> <p><b>Self-care</b> – No significant difference between groups - adjusted odds ratio 0.65; 95% CI 0.22 to 1.89; p=0.431.</p> <p><b>Pain/discomfort</b> – No significant difference between groups - adjusted odds ratio 2.18; 95% CI 0.64 to 7.41; p=0.212.</p> <p><b>Anxiety/depression</b> – No significant difference between groups - adjusted odds ratio 0.34; 95% CI 0.11 to 1.05; p=0.060.</p> <p><b>Likelihood of being classified as a clinical case of anxiety or depression (adjusted for baseline proportions) at six months:</b></p> <p><b>Anxiety</b> – No significant difference between groups - adjusted odds ratio 1.22; 95% CI 0.376 to 3.97; p=0.739.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>to participants with multiple disabilities.</p> <ul style="list-style-type: none"> <li>• Duration, frequency, intensity, etc. - Not reported clearly. The revised protocol states that the researchers expected that 95% of participants would have completed rehabilitation by 16 weeks however in their discussion of costs the authors report that most ‘... but not all patients had completed their rehabilitation programme at 213 days’ (p33).</li> <li>• Key components and objectives of intervention - Not reported.</li> <li>• Content/session titles - N/A.</li> <li>• Location/place of delivery - Participant’s own home.</li> </ul> <p><b>Comparison intervention:</b></p> <ul style="list-style-type: none"> <li>• Day hospital based multidisciplinary rehabilitation. Details are not reported except to state that these services typically provided rehabilitation, and functional assessment, as</li> </ul>	<p><b>Depression</b> – No significant difference between groups - adjusted odds ratio 0.86; 95% CI 0.29 to 2.60; p=0.793.</p> <p><b>Effect of place of care on outcomes at six months (post hoc analysis adjusting for baseline scores) –</b></p> <p><b>Activities of daily living measured using the Nottingham Extended Activities of Daily Living Scale (total score):</b> Care provided in the home is not inferior to care provided in the day hospital.</p> <p><b>Health related quality of life measured using the EUROQUOL 5 dimensions (questionnaire):</b> Care provided in the home is not inferior to care provided in the day hospital.</p> <p><b>Health related quality of life measured using the EUROQUOL 5 dimensions (visual analogue scale):</b> Care provided in the home is not inferior to care provided in the day hospital.</p> <p><b>Anxiety measured using the Hospital Anxiety and Depression Scale:</b> It is not possible to reject the null hypothesis that home based rehabilitation is inferior to day hospital based rehabilitation.</p> <p><b>Depression measured using the Hospital Anxiety and Depression Scale:</b> Care provided in the home is not inferior to care</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>well as medical, nursing, respite and social care.</p> <ul style="list-style-type: none"> <li>Delivered by - The authors describe the services as multidisciplinary.</li> </ul> <p>North Tyneside: Services staffed by acute hospital nurses, 'other form of nurse', hospital doctor, occupational therapists, physiotherapists, social workers, assistants, administrative staff and 'other'.</p> <p>Chippenham: Services staffed by GPs, acute hospital nurses, community hospital nurses, hospital doctors, occupational therapists, physiotherapists, and assistants.</p> <p>Newcastle upon Tyne: Services staffed by acute hospital nurses, 'other form of nurse', hospital doctors, occupational therapists, physiotherapists, social workers, assistants, administrative staff, and 'other'.</p> <p>Barnsley: Services staffed by acute hospital nurses, hospital doctors, occupational</p>	<p>provided in the day hospital. NB Effect on other outcomes not measured/not reported.</p> <p><b>Six months follow-up – last observation carried forward analysis –</b></p> <p><b>Activities of daily living measured using the Nottingham Extended Activities of Daily Living Scale (total score):</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) -3.222; 95% CI -7.687 to 1.243; p=0.155.</p> <p><b>Health related quality of life measured using the EUROQUOL 5 dimensions (questionnaire):</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) 0.011; 95% CI -0.109 to 0.131; p=0.857.</p> <p><b>Health related quality of life measured using the EUROQUOL 5 dimensions (visual analogue scale):</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) -2.937; 95% CI -8.991 to 3.117; p=0.337.</p> <p><b>Anxiety measured using the Hospital Anxiety and Depression Scale:</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) -0.347; 95% CI -1.843 to 1.160; p=0.648.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>therapists, physiotherapists, and administrative staff.</p> <ul style="list-style-type: none"> <li>• Delivered to - Older people referred for multi-disciplinary rehabilitation.</li> <li>• Duration, frequency, intensity, etc. - Not reported in detail. The authors note that sessions usually last for half a day or a full day.</li> <li>• Key components and objectives of intervention - Not reported.</li> <li>• Content/session titles - N/A.</li> <li>• Location/place of delivery - Day hospital (no further details provided).</li> </ul> <p><b>Outcomes measured:</b></p> <p>Service user related outcomes –</p> <ul style="list-style-type: none"> <li>• Activities of daily living was measured using the Nottingham Extended Activities of Daily Living Scale (Nouri and Lincoln, 1987). This scale contains 4 dimensions which each include a number of items measured on 4 point Likert</li> </ul>	<p><b>Depression measured using the Hospital Anxiety and Depression Scale:</b> Significant difference between groups in favour of the intervention - mean estimated difference (adjusted for baseline scores) 1.357; 95% CI 0.050 to 2.663; p=0.042.</p> <p><b>Twelve months follow-up (observed case data set) – Activities of daily living measured using the Nottingham Extended Activities of Daily Living Scale (total score):</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) 1.39; 95% CI -6.11 to 8.88; p=0.710.</p> <p><b>Anxiety measured using the Hospital Anxiety and Depression Scale:</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) 0.223; 95% CI -1.906 to 2.351; p=0.834.</p> <p><b>Depression measured using the Hospital Anxiety and Depression Scale:</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) -0.167; 95% CI -2.423 to 2.089; p=0.882.</p> <p><b>Health related quality of life measured using the EUROQUOL 5 dimensions (questionnaire):</b> No significant difference</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>scales; mobility (six items); kitchen (five items); domestic (five items); and leisure (six items). Each response to the individual item was assigned a score from 0-3 which was combined to produce a score for each dimension. These were then combined to produce an overall score for activities of daily living. These ranged from 0-66; and higher scores corresponded to greater levels of independence.</p> <ul style="list-style-type: none"> <li>Anxiety and depression was measured using the Hospital Anxiety and Depression Scale (Zigmond and Snaith, 1983). This consists of 2 subscales measuring anxiety (seven items) and depression (seven items). Scores on each subscale are combined to create a total score ranging from 0 (no problems) to 21 (lots of problems). Scores of 8 or more are generally perceived to be associated with greater likelihood of clinical diagnosis.</li> </ul>	<p>between groups - mean estimated difference (adjusted for baseline scores) 0.147; 95% CI -0.051 to 0.345; p=0.141.</p> <p><b>Health related quality of life measured using the EUROQUOL 5 dimensions (visual analogue scale):</b> No significant difference between groups - mean estimated difference (adjusted for baseline scores) 6.315; 95% CI -3.184 to 15.815; p=0.187.</p> <p><b>At end of rehabilitation programme (observed case data set) –</b></p> <p><b>Therapist-rated level of rehabilitation measured using the Therapy Outcomes Measure.</b></p> <p><b>Impairment –</b> No significant differences between groups - Mann-Whitney U test 188.50; p=0.455.</p> <p><b>Activity –</b> No significant differences between groups - Mann-Whitney U test 211.50; p=0.613.</p> <p><b>Social participation –</b> No significant differences between groups - Mann-Whitney U test 199.0; p=0.421.</p> <p><b>Wellbeing –</b> No significant differences between groups - Mann-Whitney U test 218.00; p=0.718.</p> <p><b>Repeated measures ANOVA –</b></p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>Health related quality of life was measured using the EUROQUOL (Bowling 1995). Includes a visual analogue scale which respondents use to rate their health on a scale of 0 (worst health imaginable) to 100 (best health imaginable); and 5 questionnaire items relating to 5 dimensions of health (anxiety and depression, mobility, pain or discomfort, self-care, and usual activities). Responses to each of these items are 'no problems', 'some problems', or 'cannot perform task' which results in a possible <math>3^5=243</math> health states. These states can then be transformed into a weighted health state index. The authors also used the questionnaire items to determine the number of participants who experienced difficulties in any of these areas over the follow-up period (on the advice of the scale's publishers).</li> <li>Therapist-rated level of rehabilitation was measured</li> </ul>	<p><b>Activities of daily living measured using the Nottingham Extended Activities of Daily Living Scale (total score) –</b>  Group effect: No significant difference between groups; <math>p=0.898</math>.  Follow-up effect: No significant effect of time; <math>p=0.877</math>. Group x follow-up interaction effect: No significant effect of group x time interaction; <math>p=0.410</math>.</p> <p><b>Anxiety measured using the Hospital Anxiety and Depression Scale –</b>  Group effect: No significant difference between groups; <math>p=0.180</math>.  Follow-up effect: Significant effect of time; <math>p = 0.001</math>. Group x follow-up interaction effect: No significant effect of group x time interaction; <math>p=0.219</math>.</p> <p><b>Depression measured using the Hospital Anxiety and Depression Scale –</b>  Group effect: No significant difference between groups; <math>p=0.725</math>. Follow-up effect: Significant effect of time; <math>p=0.017</math>. Group x follow-up Interaction effect: No significant effect of group x time interaction; <math>p=0.225</math>.</p> <p><b>Health related quality of life measured using the EUROQUOL 5 dimensions (questionnaire) –</b></p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>using the Therapy Outcomes Measure (Enderby and John, 1997). Includes 4 dimensions ‘... impairment (degree of severity of disorder), disability/activity (degree of limitation), social participation (degree of psychosocial engagement) and well-being (effect on emotion/level of distress) – with each dimension scored on an 11-point ordinal scale (0–5, including half-points). Lower scores indicate higher levels of impairment’ (p25). Scores were classified as 0.0 and 0.5 was classified as profound; 1.0-1.5 severe 1.0-1.5; severe/moderate 2.0-2.5; moderate 3.0-3.5; mild 4.0-4.5; and normal 5.</p> <p>Family or caregiver related outcomes – Carer psychological wellbeing was measured using the General Health Questionnaire-30 (Bowling 1995). Consists of 30 items each with a possible response of ‘better/healthier than</p>	<p>Group effect: No significant difference between groups; p=0.815. Follow-up effect: No significant effect of time; p=0.677. Group x follow-up interaction effect: Significant effect of group x time interaction p=0.002.</p> <p><b>Health related quality of life measured using the EUROQUOL 5 dimensions (visual analogue scale) –</b> Group effect: No significant difference between groups; p=0.954. Follow-up effect: No significant effect of time; p=0.217. Group x follow-up Interaction effect: No significant effect of group x time interaction; p=0.956.</p> <p><b>Last observation carried forward analysis -</b></p> <p><b>Effect of place of care on outcomes at six months (post hoc analysis adjusting for baseline scores) –</b> <b>Activities of daily living measured using the Nottingham Extended Activities of Daily Living Scale (total score):</b> Care provided in the home is not inferior to care provided in the day hospital.</p> <p><b>Health related quality of life measured using the EUROQUOL 5 dimensions (questionnaire):</b> Care provided in the home is not inferior to care provided in the day hospital.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>normal'; 'same as usual'; 'worse/more than usual' to 'much worse/more than usual'. Each item was scored between 0 and 3 and individual scores were combined to produce a single index score. Higher scores corresponded to greater severity of condition.</p> <p>Service outcomes –</p> <ul style="list-style-type: none"> <li>• Frequency of hospital admissions for each participant were recorded during the 12 month follow-up period using local hospital information systems.</li> <li>• Length of stay for those participants admitted to hospital during the follow-up period were recorded using local hospital information systems.</li> </ul> <p><b>Follow-up:</b> 3, 6 and 12 months post-randomisation.</p> <p><b>Costs?</b> Cost information - Includes data on costs and resource use.</p>	<p><b>Health related quality of life measured using the EUROQUOL 5 dimensions (visual analogue scale):</b> Care provided in the home is not inferior to care provided in the day hospital.</p> <p><b>Anxiety measured using the Hospital Anxiety and Depression Scale:</b> It is not possible to reject the null hypothesis that home based rehabilitation is inferior to day hospital based rehabilitation.</p> <p><b>Depression measured using the Hospital Anxiety and Depression Scale:</b> Care provided in the home is not inferior to care provided in the day hospital. NB Effect on other outcomes not measured/not reported.</p> <p><b>Comparison between estimated group differences derived from observed case data set (primary analysis), intention to treat analysis, and mixed models for repeated measures (using all available data) –</b></p> <p><b>Activities of daily living measured using the Nottingham Extended Activities of Daily Living Scale (total score):</b> Observed case data set: Mean difference -2.139 (95% CI -6.870 to 2.592). Last observation carried forward data set: Mean difference -3.222 (95% -7.687 CI to 1.243). Mixed models for</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>repeated measures analysis: Mean difference -4.150 (95% -10.083 CI to 1.784).</p> <p><b>Health related quality of life measured using the EUROQUOL 5 dimensions (questionnaire):</b> Observed case data set: Mean difference 0.023 (95% CI -0.114 to 0.161). Last observation carried forward data set: Mean difference 0.011 (95% CI -0.109 to 0.131). Mixed models for repeated measures analysis: Mean difference 0.161 (95% CI -0.007 to 0.329).</p> <p><b>Health related quality of life measured using the EUROQUOL 5 dimensions (visual analogue scale):</b> Observed case data set: Mean difference -1.601 (95% CI -8.809 to 5.607). Last observation carried forward data set: Mean difference -2.937 (95% CI -8.991 to 3.117). Mixed models for repeated measures analysis: Unable to obtain estimates due to data set limitations.</p> <p><b>Anxiety measured using the Hospital Anxiety and Depression Scale:</b> Observed case data set: Mean difference -0.578 (95% CI -2.409 to 1.253). Last observation carried forward data set: Mean difference -0.347 (95% CI -1.843 to 1.160). Mixed models for repeated measures analysis: Mean difference -0.213 (95% CI -2.393 to 1.968).</p> <p><b>Depression measured using the Hospital Anxiety and Depression Scale:</b> Observed</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>case data set: Mean difference 1.033 (95% CI -0.441 to 2.507). Last observation carried forward data set: Mean difference 1.357 (95% CI 0.050 to 2.663). Mixed models for repeated measures analysis: Mean difference 2.280 (95% CI 0.185 to 4.374).</p> <p>Family or caregiver related outcomes -  <b>Carer psychological wellbeing measured using the General Health Questionnaire (observed case data set):</b>  Three months follow-up - No significant difference between groups - mean difference -2.04; 95% CI -10.89 to 6.80; p=0.644.  Six months follow-up (observed case data set) – Carer psychological wellbeing measured using the General Health Questionnaire: No significant difference between groups - mean difference -0.883; 95% CI -10.75 to 8.979; p=0.857.  Twelve months follow-up (observed case data set) – Carer psychological wellbeing measured using the General Health Questionnaire: No significant difference between groups - mean difference -0.239; 95% CI -8.73 to 8.251; p=0.954.</p> <p>Service outcomes -  <b>Resource use at six months –</b></p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Use of primary care: Participants in the control group used significantly less primary care than those in the intervention group - <math>p=0.02</math>.</p> <p>Outpatient visits: No significant difference between groups - <math>p=0.71</math>.</p> <p>Emergency ambulance use: No significant difference between groups - <math>p=0.84</math>.</p> <p>Patient transportation service use: No significant difference between groups - <math>p=0.76</math>.</p> <p>Home visits (not including GP): No significant difference between groups - <math>p=0.21</math>.</p> <p>Drugs (£): No significant difference between groups - <math>p=0.61</math>.</p> <p>Nursing home stay (days): No significant difference between groups - <math>p=0.32</math>.</p> <p>Day care use (days): No significant difference between groups - <math>p=0.61</math>.</p> <p>Private care expenditure (£): No significant difference between groups - <math>p=0.85</math>.</p> <p>Home assistance (£): No significant difference between groups - <math>p=0.59</math>.</p> <p>Home assistance excluding outlier participant: No significant difference between groups - <math>p=0.76</math>.</p> <p>Informal care (hours): No significant difference between groups - <math>p=0.68</math>.</p> <p><b>Resource use at twelve months –</b></p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Use of primary care: No significant difference between groups - <math>p=0.44</math>.</p> <p>Outpatient visits: No significant difference between groups - <math>p=0.87</math>.</p> <p>Emergency ambulance use: No significant difference between groups - <math>p=1</math>.</p> <p>Patient transportation service use: No significant difference between groups - <math>p=0.48</math>.</p> <p>Home visits (not including GP): No significant difference between groups - <math>p=0.27</math>.</p> <p>Drugs (£): No significant difference between groups - <math>p=0.46</math>.</p> <p>Nursing home stay (days): No significant difference between groups - <math>p=0.63</math>.</p> <p>Day care use (days): No significant difference between groups - <math>p=0.37</math>.</p> <p>Private care expenditure (£): No significant difference between groups - <math>p=0.89</math>.</p> <p>Home assistance (£): No significant difference between groups - <math>p=0.97</math>.</p> <p>Home assistance excluding outlier participant: No significant difference between groups - <math>p=0.87</math>.</p> <p>Informal care (hours): No significant difference between groups - <math>p=0.88</math>.</p> <p>Frequency of hospital admissions over 12 month follow-up period: No significant</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>difference between groups - odds ratio 0.75; 95% CI 0.62 to 3.47; p=0.383.</p> <p>Length of stay for participants who had at least 1 hospital admission during 12 month follow-up period: No significant difference between groups - mean difference 9.3 days; 95% CI -12.5 to 31.1 days.</p> <p>Duration of stay per hospital admission during 12 month follow-up period: No significant difference between groups – control = 15.8 days vs intervention = 16.4 days; p=0.936.</p> <p>Effect of place of care on number of hospital admissions over 12 month follow-up period: No significant effect of place of care - <math>\exp\beta=0.68</math>; 95% CI 0.41 to 1.12; p=0.130.</p> <p><b>Narrative findings – effectiveness –</b></p> <p>Service user related outcomes –</p> <p><b>Three months follow-up (observed case data set) –</b></p> <p>Activities of daily living measured using the Nottingham Extended Activities of Daily Living Scale (total score): No significant difference between groups. Anxiety measured using the Hospital Anxiety and Depression Scale: No significant difference between groups.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Depression measured using the Hospital Anxiety and Depression Scale: No significant difference between groups.</p> <p>Health related quality of life measured using the EUROQUOL 5 dimensions (questionnaire): Significant difference between groups in favour of the control.</p> <p>Health related quality of life measured using the EUROQUOL 5 dimensions (visual analogue scale): No significant difference between groups.</p> <p><b>Six months follow-up (observed case data set)</b> - Activities of daily living measured using the Nottingham Extended Activities of Daily Living Scale (total score): No significant difference between groups.</p> <p>Activities of daily living measured using the Nottingham Extended Activities of Daily Living mobility subscale: No significant difference between groups.</p> <p>Activities of daily living measured using the Nottingham Extended Activities of Daily Living kitchen subscale: No significant difference between groups.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Activities of daily living measured using the Nottingham Extended Activities of Daily Living domestic subscale: No significant difference between groups.</p> <p>Activities of daily living measured using the Nottingham Extended Activities of Daily Living leisure subscale: No significant difference between groups.</p> <p>Household activities of daily living measured using the Nottingham Extended Activities of Daily Living domestic and kitchen subscales (composite): No significant difference between groups.</p> <p>Anxiety measured using the Hospital Anxiety and Depression Scale: No significant difference between groups.</p> <p>Depression measured using the Hospital Anxiety and Depression Scale: No significant difference between groups.</p> <p>Health related quality of life measured using the EUROQUOL 5 dimensions (questionnaire): No significant difference between groups.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Health related quality of life measured using the EUROQUOL 5 dimensions (visual analogue scale): No significant difference between groups.</p> <p><b>Proportion of participants classifying themselves as having experienced a problem in 1 of the five domains of health related quality of life measured using the EUROQUOL 5 dimensions (adjusted for baseline proportions) at six months:</b></p> <p>Mobility – No significant difference between groups.  Usual activities – No significant difference between groups.  Self-care – No significant difference between groups. Pain/discomfort – No significant difference between groups.  Anxiety/depression – No significant difference between groups.</p> <p><b>Likelihood of being classified as a clinical case of anxiety or depression (adjusted for baseline proportions) at six months:</b></p> <p>Anxiety – No significant difference between groups. Depression – No significant difference between groups.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p><b>Effect of place of care on outcomes at six months (post hoc analysis adjusting for baseline scores) –</b></p> <p>Activities of daily living measured using the Nottingham Extended Activities of Daily Living Scale (total score): Care provided in the home is not inferior to care provided in the day hospital.</p> <p>Health related quality of life measured using the EUROQUOL 5 dimensions (questionnaire): Care provided in the home is not inferior to care provided in the day hospital.</p> <p>Health related quality of life measured using the EUROQUOL 5 dimensions (visual analogue scale): Care provided in the home is not inferior to care provided in the day hospital.</p> <p>Anxiety measured using the Hospital Anxiety and Depression Scale: It is not possible to reject the null hypothesis that home based rehabilitation is inferior to day hospital based rehabilitation.</p> <p>Depression measured using the Hospital Anxiety and Depression Scale: Care provided in the home is not inferior to care provided in the day hospital.</p> <p>NB Effect on other outcomes not measured/not reported.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p><b>Six months follow-up – last observation carried forward analysis –</b>            Activities of daily living measured using the Nottingham Extended Activities of Daily Living Scale (total score): No significant difference between groups.            Health related quality of life measured using the EUROQUOL 5 dimensions (questionnaire): No significant difference between groups.            Health related quality of life measured using the EUROQUOL 5 dimensions (visual analogue scale): No significant difference between groups.            Anxiety measured using the Hospital Anxiety and Depression Scale: No significant difference between groups.            Depression measured using the Hospital Anxiety and Depression Scale: Significant difference between groups in favour of the intervention.</p> <p><b>Twelve months follow-up (observed case data set) –</b> Activities of daily living measured using the Nottingham Extended Activities of Daily Living Scale (total score): No significant difference between groups.            Anxiety measured using the Hospital Anxiety and Depression Scale: No significant difference between groups.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Depression measured using the Hospital Anxiety and Depression Scale: No significant difference between groups.</p> <p>Health related quality of life measured using the EUROQUOL 5 dimensions (questionnaire): No significant difference between groups.</p> <p>Health related quality of life measured using the EUROQUOL 5 dimensions (visual analogue scale): No significant difference between groups.</p> <p><b>At end of rehabilitation programme (observed case data set) – Therapist-rated level of rehabilitation measured using the Therapy Outcomes Measure.</b></p> <p>Impairment - No significant differences between groups. Activity - No significant differences between groups. Social participation - No significant differences between groups. Wellbeing - No significant differences between groups.</p> <p><b>Repeated measures ANOVA –</b></p> <p>Activities of daily living measured using the Nottingham Extended Activities of Daily Living Scale (total score) - Group effect: No significant difference between groups. Follow-up effect: No significant effect of time.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Group x follow-up interaction effect: No significant effect of group x time interaction. Anxiety measured using the Hospital Anxiety and Depression Scale –</p> <p>Group effect: No significant difference between groups. Follow-up effect: Significant effect of time; p=0.001. Group x follow-up interaction effect: No significant effect of group x time interaction.</p> <p>Depression measured using the Hospital Anxiety and Depression Scale –</p> <p>Group effect: No significant difference between groups. Follow-up effect: Significant effect of time.</p> <p>Group x follow-up Interaction effect: No significant effect of group x time interaction. Health related quality of life measured using the EUROQUOL 5 dimensions (questionnaire)</p> <p>Group effect: No significant difference between groups. Follow-up effect: No significant effect of time.</p> <p>Group x follow-up interaction effect: Significant effect of group x time interaction p= 0.002.</p> <p>Health related quality of life measured using the EUROQUOL 5 dimensions (visual analogue scale) –</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Group effect: No significant difference between groups. Follow-up effect: No significant effect of time.</p> <p>Group x follow-up Interaction effect: No significant effect of group x time interaction.</p> <p><b>Last observation carried forward analysis</b> -</p> <p><b>Effect of place of care on outcomes at six months (post hoc analysis adjusting for baseline scores)</b> - Activities of daily living measured using the Nottingham Extended Activities of Daily Living Scale (total score): Care provided in the home is not inferior to care provided in the day hospital.</p> <p>Health related quality of life measured using the EUROQUOL 5 dimensions (questionnaire): Care provided in the home is not inferior to care provided in the day hospital.</p> <p>Health related quality of life measured using the EUROQUOL 5 dimensions (visual analogue scale): Care provided in the home is not inferior to care provided in the day hospital.</p> <p>Anxiety measured using the Hospital Anxiety and Depression Scale: It is not possible to reject the null hypothesis that home based</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>rehabilitation is inferior to day hospital based rehabilitation.</p> <p>Depression measured using the Hospital Anxiety and Depression Scale: Care provided in the home is not inferior to care provided in the day hospital.</p> <p>NB Effect on other outcomes not measured/not reported.</p> <p><b>Comparison between estimated group differences derived from observed case data set (primary analysis), intention to treat analysis, and mixed models for repeated measures (using all available data) –</b></p> <p>The authors compared results derived from different analysis methods and found that mean effects were generally larger when derived from the mixed models for repeated measures analysis or last observation carried forward data set.</p> <p>Family or caregiver related outcomes –</p> <p><b>Carer psychological wellbeing (observed case data set) – measured using the General Health Questionnaire:</b></p> <p>Three months follow-up - No significant difference between groups.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Six months follow-up – Carer psychological wellbeing measured using the General Health Questionnaire: No significant difference between groups.</p> <p>Twelve months follow-up – Carer psychological wellbeing measured using the General Health Questionnaire: No significant difference between groups.</p> <p>Service outcomes –</p> <p><b>Resource use at six months –</b></p> <p>Use of primary care: Participants in the control group used significantly less primary care than those in the intervention group.</p> <p>Outpatient visits: No significant difference between groups. Emergency ambulance use: No significant difference between groups.</p> <p>Patient transportation service use: No significant difference between groups.</p> <p>Home visits (not including GP): No significant difference between groups.</p> <p>Drugs (£): No significant difference between groups. Nursing home stay (days): No significant difference between groups.</p> <p>Day care use (days): No significant difference between groups.</p> <p>Private care expenditure (£): No significant difference between groups.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Home assistance (£): No significant difference between groups.  Home assistance excluding outlier participant: No significant difference between groups.  Informal care (hours): No significant difference between groups.</p> <p><b>Resource use at twelve months –</b>  Use of primary care: No significant difference between groups.  Outpatient visits: No significant difference between groups. Emergency ambulance use: No significant difference between groups.  Patient transportation service use: No significant difference between groups.  Home visits (not including GP): No significant difference between groups.  Drugs (£): No significant difference between groups. Nursing home stay (days): No significant difference between groups.  Day care use (days): No significant difference between groups.  Private care expenditure (£): No significant difference between groups.  Home assistance (£): No significant difference between groups.  Home assistance excluding outlier participant: No significant difference between groups.  Informal care (hours): No significant difference between groups.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Frequency of hospital admissions over 12 month follow-up period: No significant difference between groups.</p> <p>Length of stay for participants who had at least 1 hospital admission during 12 month follow-up period: No significant difference between groups.</p> <p>Duration of stay per hospital admission during 12 month follow-up period: No significant difference between groups.</p> <p>Effect of place of care on number of hospital admissions over 12 month follow-up period: No significant effect of place of care.</p>	

**5. Thorsen AM, Widen Holmqvist L, Von Koch L (2006) Early Supported Discharge and continued rehabilitation at home after stroke: 5-year follow-up of resource use. Journal of Stroke and Cerebrovascular Diseases 15(4): 139-43**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The aim of the study was to assess the effect of Early Supported Discharge on use of health care and social service resources 5 years after stroke. NB.</p>	<p><b>Participants:</b> Service users and their families, partners and carers. Participants were service users after stroke.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - The mean age of participants was 72 years.</li> <li>• Sex - This is not reported.</li> </ul>	<p><b>Findings - effect sizes:</b></p> <p>A difference in the mean total length of hospitalisation was observed (51 days in control group vs. 32 days in Early Supported Discharge group; mean difference -19.2 [95% CI -35.7 to -2.7] p=0.02).</p> <p>Participants in the CRG used outpatient rehabilitation more frequently than Early</p>	<p><b>Overall assessment of internal validity:</b></p> <p>-</p> <p><b>Overall assessment of external validity:</b></p> <p>++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>This is 1 of 2 follow-up studies, the first of which explores changes in perceived health status over the 5 years after stroke onset (Ytterberg et al. 2010), thus providing an overall picture.</p> <p><b>Methodology:</b> RCT. This study followed-up an RCT that was conducted in 2000. Participants were randomised to Early Supported Discharge or conventional rehabilitation.</p> <p><b>Country:</b> Sweden.</p> <p><b>Source of funding:</b> Other - The study was supported by grants from the</p>	<ul style="list-style-type: none"> <li>• Ethnicity - This is not reported.</li> <li>• Religion/belief - This is not reported.</li> <li>• Disability - This is not reported.</li> <li>• Long term health condition - There was a greater proportion of patients in the Early Supported Discharge group with a history of conditions associated with stroke, particularly transient ischemic attack and diabetes mellitus.</li> <li>• Sexual orientation - This is not reported.</li> <li>• Socioeconomic position - This is not reported.</li> </ul> <p><b>Sample size –</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers: n=24.</li> <li>• Intervention numbers: n=30.</li> <li>• Sample size: 54 participants were followed-up in this study.</li> </ul> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Describe intervention - Early supported discharge from hospital and continued rehabilitation at home.</li> </ul>	<p>Supported Discharge group participants (mean difference -11.8 [95% CI -22.8 to -0.7, p=.04), including physiotherapy in primary care (mean difference -4.7 [95% CI -9.2 to -0.1] p=.05).</p> <p><b>Narrative findings – effectiveness:</b> A significant difference in mean total length of hospitalisation was present at 5 year follow-up.</p> <p>In addition to this, participants in the Early Supported Discharge group used less resources than participants in the control group.</p> <p>There was no difference between the 2 groups in the use of community-based social service or informal care for the period of the previous 6 months.</p>	<p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>Swedish Association of Neurologically Disabled, the Swedish Stroke Association, Solstickan Foundation, and the Center for Health Care Sciences, Karolinska Institutet.</p>	<ul style="list-style-type: none"> <li>• Delivered by - The intervention was delivered by an outreach team of occupational therapists, physiotherapists, and a speech and language therapist.</li> <li>• Delivered to - The intervention was delivered to participants allocated to the Early Supported Discharge condition.</li> <li>• Duration, frequency, intensity, etc. - The mean duration of the intervention program was 14 weeks and the mean number of home visits was 12.</li> <li>• Key components and objectives of intervention - Key components and objectives of the intervention were to reduce the risk of death or dependency, shorten the length of hospitalisation, improve independence in extended activities of daily living (ADL), and increase satisfaction with services and the likelihood of living at home.</li> <li>• Content/session titles - The content of the intervention was</li> </ul>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>decided upon together with the participant and his or her family, however, the most common foci of home visits were speech and communication, ADL, and ambulation.</p> <ul style="list-style-type: none"> <li>• Location/place of delivery - The intervention was delivered in participants' homes.</li> </ul> <p><b>Comparison intervention:</b> Participants in the comparison intervention received their rehabilitation in the stroke department until discharge. The content and duration of this did not adhere to a standardised program, but rather reflected services available within the District Health Authority.</p> <p><b>Outcomes measured:</b> <u>Service outcomes -</u> This study's main outcome measure was the effect of Early Supported Discharge services on use of health care and social service resources 5 years after</p>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>stroke. The following measures were used to gather data - a computerised register of Stockholm County Council - telephone conversations and consultation visits - interviews with participants and/or their spouses.</p> <p><b>Follow-up:</b> Participants were assessed at baseline and followed-up 5 years later.</p> <p><b>Costs?</b> No. No calculation of cost was performed of the 5 year resource use of health care.</p>		

**6. Ytterberg C, Thorsen AM, Liljedahl M et al. (2010) Changes in perceived health between one and five years after stroke: A randomized controlled trial of early supported discharge with continued rehabilitation at home versus conventional rehabilitation. Journal of the Neurological Sciences 294: 86-8**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> To explore perceived health status in people with stroke who received Early Supported</p>	<p><b>Participants:</b> Service users and their families, partners and carers - Participants were service users who had been diagnosed with first or recurrent stroke, according to the World Health</p>	<p><b>Findings - effect sizes:</b> Effect sizes not reported by the authors. Effect sizes presented here were calculated by the review team. There was no difference between the groups at 1 or 5 years after stroke with regard to Sickness Impact Profile total, except for a higher impact</p>	<p><b>Overall assessment of internal validity:</b> + Conclusions are in</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>Discharge, with those who received conventional rehabilitation, over 5 years after stroke onset.</p> <p>NB. This is 1 of 2 follow-up studies, the second of which explores the effect of Early Supported Discharge services on use of health care and social service resources 5 years after stroke onset (Thorsen et al., 2006), thus providing an overall picture.</p> <p><b>Methodology:</b> RCT. This study followed-up an RCT that was conducted in 2000. Participants were randomised to Early Supported</p>	<p>Organization's clinical criteria for acute stroke.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Follow-up age was 71 in the home rehabilitation group and 70 in the conventional rehabilitation group.</li> <li>• Sex - 13 women were in the home rehabilitation group, 8 women were in the conventional rehabilitation group.</li> <li>• Ethnicity - 25 participants in the home rehabilitation were Swedish, as were 20 from the conventional rehabilitation group. Other ethnicities are not reported.</li> <li>• Religion/belief – Not reported.</li> <li>• Disability - Not reported.</li> <li>• Sexual orientation - Not reported.</li> <li>• Socioeconomic position - Three participants from the home rehabilitation group were classed as 'working', as were 4 from the conventional rehabilitation group.</li> </ul>	<p>in the home rehabilitation group at 1 year after stroke with regard to communication (p=0.01) and at 5 years after stroke with regard to eating (p=0.04).</p> <p>Sickness Impact Profile total did not change significantly between 1 and 5 years in the home rehabilitation group, whereas it deteriorated significantly (p=0.05) in the conventional rehabilitation group.</p> <p>Body care deteriorated in the conventional rehabilitation group (p=0.03) and emotional behaviour was improved in both groups (home rehabilitation group, p=0.04; conventional rehabilitation group, p=0.04).</p> <p>Baseline characteristics of patients in the home rehabilitation group (HRG) and the conventional rehabilitation group (CRG) assessed with regard to perceived health 5 years after stroke: Timed 10m walk: d=0.1803; 95% Confidence Interval -0.3792 to 0.7398; Nine-Hole Peg Test right, pegs/min: d = -0.2466; 95% CI -0.8071 to 0.3139; Nine-Hole Peg Test left, pegs/min: d = 0.1776; 95% CI -0.3819 to 0.7371.</p> <p><b>Narrative findings – effectiveness:</b> There</p>	<p>line with study findings, which suggest that the long term outcome with regard to perceived health status is more favourable after Early Supported Discharge than after conventional rehabilitation.</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>Discharge or conventional rehabilitation.</p> <p><b>Country:</b> Sweden.</p> <p><b>Source of funding:</b> Other - The study was supported by grants from the Swedish Stroke Association and from the Swedish Council for working life and social research (FAS).</p>	<p><b>Sample size –</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers: At baseline, n=41 and at follow-up (5 years later), n=24 - although only 22 were assessed with regards to perceived health.</li> <li>• Intervention numbers: At baseline, n=42 and at follow-up (5 years later), n=30 - although only 28 were assessed with regards to perceived health.</li> <li>• Sample size: N=83 (before allocation). The total number of participants that were assessed with regards to perceived health was 50.</li> </ul> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Describe intervention - Early supported discharge from hospital and continued rehabilitation at home. Further details are not provided in this study.</li> <li>• Delivered by - A multidisciplinary team.</li> </ul>	<p>was no difference in perceived health between the groups at 1 or 5 years after stroke with regard to Sickness Impact Profile total and the physical and psychosocial dimensions. Perceived health did not significantly change between 1 and 5 years in the home rehabilitation group whereas it had deteriorated significantly in the conventional rehabilitation group.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Delivered to - Participants allocated to the intervention condition (n=42).</li> <li>• Duration, frequency, intensity, etc.</li> <li>• Details about the intervention are not provided in this study.</li> <li>• Key components and objectives of intervention - Details about the intervention are not provided in this study, however, it is noted that the overall purpose of Early Supported Discharge is to reduce long term dependency and also admission to institutional care as well as reducing the length of hospital stay.</li> <li>• Content/session titles - Details about the intervention are not provided in this study.</li> <li>• Location/place of delivery - Details about the intervention are not provided in this study.</li> </ul> <p><b>Comparison intervention:</b> Conventional rehabilitation.</p>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>Details are not provided in this study.</p> <p><b>Outcomes measured:</b></p> <p><u>Service user related outcomes</u> - Perceived health status of service users was measured.</p> <p><b>Follow-up:</b> Follow-up was at 3 months, 6 months, 1 and 5 years after stroke.</p> <p><b>Costs?</b> No.</p>		

## Review question 1 – Findings tables – the views and experiences of people using services, their families and carers

### 1. Ariss S (2014) National audit for intermediate care: Patient reported experiences, 2014. Sheffield: University of Sheffield

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<b>Study aim:</b> To obtain views and experiences from people using intermediate care by	<b>Participants:</b> Service users and their families, partners and carers. People using intermediate care (bed based, home based or reablement).	<p><b>Narrative findings – qualitative and views and experiences data:</b></p> <p>NB. The report is published without page numbers so these cannot be provided with the</p>	<p><b>Overall assessment of internal validity:</b></p> <p>-</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>asking the following survey question: 'Do you feel that there is something that could have made your experience of the service better?'</p> <p><b>Methodology:</b> Survey.</p> <p><b>Country:</b> UK – England.</p> <p><b>Source of funding:</b> Government.</p>	<p><b>Sample size:</b> 908 (356 of whom were people using home based intermediate care).</p> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>Describe intervention - Home based intermediate care. The author does not provide a description in this report although we know that in the broader audit, home based intermediate care is defined as follows - community based services provided to service users in their own home/care home. These services will usually offer assessment and interventions supporting admission avoidance, faster recovery from illness, timely discharge from hospital and maximising independent living. Services are usually delivered by the multi-disciplinary team, but predominantly by health professionals and carers (in care homes).</li> <li>Delivered by - The author does not provide a description of</li> </ul>	<p>quotes. Statements about ways that the service might be improved were coded into 8 distinct themes, which emerged from the data. They're listed here in descending order, starting with the 1 cited most frequently.</p> <p><b>Joined up, appropriate services:</b> This theme included communication and coordination within and between services, timeliness or information about waiting times, continuity of carers, discharge arrangements, and knowledgeability and information provision about other appropriate services.</p> <p>Supporting quotes: Communication between services including information sharing – “Hours spent on assessment + no one passed on their notes so process very repetitive - exhausting!”</p> <p>Long wait between discharge and start of home based intermediate care – “I was discharged from hospital late on a Thursday, assessed on the Friday but, with the weekend intervening no OT equipment was delivered until Monday at the earliest. This meant that we had to cope for nearly 4 days without aids.”</p> <p>Abrupt end to the service - "When my care was</p>	<p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> -</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>who delivers the services in this report although we know that in the broader audit, home based intermediate care is described as being delivered by multi-disciplinary teams, but predominantly by health professionals and carers (in care homes).</p> <ul style="list-style-type: none"> <li>• Duration, frequency, intensity, etc. - Details not provided in this report but according to the NAIC, up to 6 weeks (though there will be individual exceptions).</li> <li>• Key components and objectives of intervention - Details not provided in this report but according to the NAIC, the aims of home based IC are: Intermediate care assessment and interventions supporting admission avoidance, faster recovery from illness, timely discharge from hospital and maximising independent living.</li> <li>• Location/place of delivery - Details not provided in this</li> </ul>	<p>near an end. It was very chaotic. I was told by the carer treatment would be stopped the next day."</p> <p><b>Timing of visits:</b> The timing of visits was often inappropriate, unexpected or inconsistent, and secondly more time or greater frequency of visits was considered necessary.</p> <p>Supporting quotes:  Service led, not needs led – "... wasn't my fault I needed care at weekend. Just dumped at weekend survival what's happened to public services it's a 24hour care service now it's gone to Monday-Friday 9-5."  Pattern/ frequency of visits – "More frequent visits only in the first two/three weeks of my injury".</p> <p>Communication regarding timings of visits/lack of control over daily life – "I know it is hard for the nurses to get here but if you could make it definitely morning or afternoon as I found I had to cancel appointments as I didn't know when they were actually coming am or pm."</p> <p><b>Personal communication and attention:</b>  Included lack of appropriate or consistent information about services or care,</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>report but according to the NAIC, people's own homes including care homes.</p>	<p>inappropriate or disrespectful communication, lack of discharge information, and feelings that service-users were not being listened to, or their needs understood.</p> <p>Supporting quotes: Not knowing what to expect – “If I had notice of when they would start visiting and their objectives I was rather surprised.”</p> <p>User involvement in decisions/ goal planning – “I think there is a balance to be struck between user and practitioner in making decisions about body therapy and outcomes, and I don't think you have that balance right yet.”</p> <p><b>Length of service:</b> Many respondents report anxiety or concern about the support finishing too early, before they feel adequately able to support themselves. Personal health and safety issues were also a concern. For many service-users, discharge from the service is seen as an end to their contact with any support services, which could reflect a lack of access to appropriate long-term, low-level support.</p> <p>Supporting quotes: The service was perceived to have been terminated too early – “I had a broken hip just discharged and</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>received 1 visit only. I would have liked more longer term involvement support to regain full mobility asap but a 45 min one off visit was all I was allowed. Very poor.”</p> <p>- “My legs are weak and shaky. Whilst the carers were here I had more confidence and my walking was improving I would have liked there help for a bit longer”.</p> <p>- “I felt I still needed support and staff could have continued until I was more confident in myself (stopped at 4 weeks)”.</p> <p><b>Staffing:</b> The main concerns were lack of provider continuity, and shortage of staff. Impacts on many other important aspects of care, such as rushed visits, not enough time to share information, unpredictable and inappropriate visit times, inconsistent standards of care and lack of understanding about individuals’ needs.</p> <p>Supporting quotes: Impact of lack of continuity – “To have same person who knew your case”.</p> <p><b>Personal care:</b> No particular themes for home based intermediate care in relation to personal care - just individual reasons for unmet needs – “I have not achieved all that was intended i.e. I</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>am unable to go shopping because a) I am unable to walk without 2 sticks is am unable to carry any shopping and b) have not the confidence to go far on my own. So far I have been unable to walk as far as the local shop.”</p> <p><b>Therapy and assessment:</b> The responses for home based services specifically mentioned more physiotherapy as an identified area of service improvement, “I wanted physiotherapy to help me to walk unaided but I was put on a waiting list!”</p>	

**2. Cobley CS, Fisher RJ, Chouliara N et al. (2013) A qualitative study exploring patients' and carers' experiences of Early Supported Discharge services after stroke. Clinical Rehabilitation 27(8): 750-7**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> To investigate patients' and carers' experiences of Early Supported Discharge services and inform future Early Supported Discharge service development and provision.</p>	<p><b>Participants:</b> Service users and their families, partners and carers - Stroke patients and carers.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>Age - The mean (SD) age of patients after stroke was 69.85 ± 13.42 years and mean (SD) age of carers was 72.79 ± 14.10.</li> </ul>	<p><b>Narrative findings – qualitative and views and experiences data:</b></p> <p><b>Early Supported Discharge specific themes:</b></p> <p><b>Satisfaction with rehabilitation exercises:</b> Almost all interviewees (17 of 19) reported feeling satisfied with the various exercises they had been taught and left to complete, enabling optimal functional recovery. Patients often commented on the benefits of receiving</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p>With the caveat</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Methodology:</b> Qualitative study - semi structured interviews with patients and carers.</p> <p><b>Country:</b> United Kingdom - England, Nottinghamshire.</p> <p><b>Source of funding:</b> Government – NIHR.</p>	<ul style="list-style-type: none"> <li>Sex - Sex of stroke patients not reported. 13 of the carers (87%) were women.</li> </ul> <p><b>Sample size:</b> 19 patients and 9 carers.</p> <p><b>Intervention:</b> Patients were recruited from 2 stroke units. Participants included those who had been referred to Early Supported Discharge and those who were not. Early Supported Discharge is not described in this paper.</p>	<p>therapeutic sessions both within and outside the home environment, “The team were encouraging and motivating and would take me on a walk to make sure I could get on a bus and that I was able to cross the road, things like that ...” (interview 12, patient: p753).</p> <p><b>Home as a better arena for rehabilitation:</b> There was a consensus of preference among participants (15 of 19) for returning to their home environment as soon as possible. Home was described as a more private and individualized arena for rehabilitation. It was perceived to be more focused toward rehabilitation outcomes, “...it was good to be given walks around the house and getting used to things that are here, such as steps and obstacles. And that has helped in that respect, getting back into the house” (interview 3, patient: p753).</p> <p><b>Time not being a carer:</b> Respite time for the carer emerged as a significant and prominent theme. Five of 9 reported that the therapeutic sessions between patient and the Early Supported Discharge (clinicians) team enabled them to engage in their own activities. By contrast, 2 carers described feeling housebound as the team were not with the</p>	<p>about Early Supported Discharge being outside the NAIC definition.</p> <p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>patient long enough to enable sufficient respite time for the carer (interview 4, carer: p753).</p> <p><b>Speed of response:</b> Sixteen of 19 patients reported feeling positively surprised with the seamless transition between hospital and home setting, with the first Early Supported Discharge home visit being made within 24 hours of hospital discharge. However 1 participant had to wait several days for the Early Supported Discharge team to make their initial visit, "It was a few days of me coming from hospital. I was left without any help at all from the Thursday to the Monday I sort of had to fend for myself ... I wished it could have started earlier than it did" (interview 12, patient: p753).</p> <p><b>Intensity of therapy:</b> The intensity of rehabilitation, up to 4 visits per day, 7 days per week for a duration of 6 weeks was received very positively by virtually every respondent (18 of 19). The consistency and regularity of visits provided a sense of security during such a life-changing transitional period.</p> <p><b>Satisfaction with provision and delivery of equipment:</b> There was a general consensus (10 of 19) among participants that the equipment provided</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>was useful and delivered in a timely manner. Nevertheless, 1 patient found the equipment provided unsuitable and 1 patient was disappointed at being promised aids that never materialized: “they’re really struggling to get these aids. So they said, we’ll probably get you a sock aid to help you put your socks on, but I didn’t get one” (interview 4, patient: p754).</p> <p><b>Disjointed transition between early supported discharge and future services:</b> Some patients felt that the 6-week cut off from Early Supported Discharge was abrupt and not continuous enough. Furthermore, some patients transferred onto further services did not feel that this transition was always well managed, “... all of a sudden it's like, 'Oh, we've referred you to the hospital again to get the physio', which has took, like, 3 months. So I've had intense physio for 6 weeks and then, for 3 months, I've had nothing” (interview 2, patient: p754).</p> <p><b>Common themes in both cohorts of interviews:</b></p> <p><b>Limited support in dealing with carer strain:</b> On discharge, carers are left feeling exhausted and physically strained with no time for leisure</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>and social activities. They have to take on new roles and responsibilities and come to terms with new relationships e.g. from wife to carer. Many respondents indicated that they felt thrown into the caring role without receiving enough support from the community stroke teams. They stressed the need for services to consider and address carers' issues, "I'm very disappointed that they didn't offer to help me, because obviously he would have had to go into a home or somewhere if I wasn't doing it. So I mean I'm saving them a lot of money and time" (interview 6, carer: p754).</p> <p><b>Lack of education and training of carers:</b> Twelve of 15 carers reported being poorly informed regarding the extent of support available after discharge, "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" (interview 6, carer: p754). The training of carers in how best to physically support the patient was described as inadequate, "I wasn't physically shown the best way to support him, it was all trial and error" (interview 8, carer: p754). Carers also highlighted their difficulty in coping with the stroke patients' emotional and psychological needs.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p><b>Inadequate provision and delivery of information:</b> In several interviews, both patients (15 of 26) and carers (10 of 14) expressed their concerns about their limited understanding of stroke and its causes, secondary preventative measures, and lifestyle changes, “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” (interview 8, patient: p754).</p> <p>Both patients and carers spoke of the difficulties they had encountered in accessing information concerning welfare benefits, carer allowance, statutory and informal support. Many participants felt information wasn’t delivered in an appropriate format and they felt it was provided too late.</p>	

**3. McLeod E, Bywaters P, Tanner D et al. (2008) For the sake of their health: Older service users' requirements for social care to facilitate access to social networks following hospital discharge. British Journal of Social Work 38: 73-90**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The evaluation did not aim to assess the effectiveness of social rehabilitation as a model and method of practice per se, nor its impact on reducing hospital re-admission. However, it provided the opportunity to study older service users' requirements for social care to facilitate access to social networks and support post-hospital discharge.</p> <p><b>Methodology:</b> Qualitative study - Data on service user experiences and views were collected mainly via</p>	<p><b>Participants:</b></p> <ul style="list-style-type: none"> <li>• Service users and their families, partners and carers - Service users.</li> <li>• Professionals/practitioners - Project coordinators from the 5 Age Concern pilots.</li> </ul> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Ranged from 57 to 101. Most were in their seventies and eighties, with a few either in their sixties or nineties.</li> <li>• Sex - Only 2 out of seventeen service users completing interviews or feedback questionnaires were men. In the sample of case records, there were also fewer men (eighteen) than women (twenty-six).</li> <li>• Ethnicity - Only 1 member of a minority ethnic group was included in the sample, reflecting feedback from project co-ordinators that a disproportionately low</li> </ul>	<p><b>Narrative findings – qualitative and views and experiences data:</b></p> <p><b>Safe transition - essential preliminary to re-engagement socially:</b> An essential requirement to older service users re-engaging with social networks following hospital discharge was safe transition between hospital and home. Several project co-ordinators encountered service users who had been discharged too soon and were too ill to cope at home. Project co-ordinators also gave several examples illustrating the need for improved levels of funding and co-ordination of health and social care services, to avert risks to health in the transfer from hospital to home.</p> <p>Example – “One Social Rehabilitation worker had made an appointment with a potential service user for the morning after her discharge. The service user had multiple health problems and could not walk. When the Social Rehabilitation worker arrived she found the woman sitting in her hallway. She had been left at the bottom of her garden drive by the hospital transport the day before. Despite her leg being in plaster, she had managed to get</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>questionnaires with a small number of telephone interviews. Also analysis of service records plus interviews with project coordinators.</p> <p><b>Country:</b> UK.</p> <p><b>Source of funding:</b> Not reported.</p>	<p>percentage of members of minority ethnic groups accessed the service.</p> <ul style="list-style-type: none"> <li>• Long term health condition - Ill-health leading to the most recent A&amp;E attendance or hospitalization was associated with long-term conditions such as heart disease. Health issues tended to take the form of multiple problems combined with various forms of impairment such as stroke, together with hearing impairment and heart conditions. There was little evidence of service users with Alzheimer's disease using the HACSR service.</li> <li>• Sexual orientation - Service records contained no information relating to service users' sexual orientation. Nor did this emerge as an issue in interviews or questionnaires.</li> </ul> <p><b>Sample size:</b> Seventeen service users and 5 project coordinators.</p>	<p>herself into the house but could not get anywhere else. She had sat, in her hospital clothes, on an upright chair in her hall all night, without food or drink" (Project A, p80).</p> <p><b>Assistance with practical home care/ personal care:</b> A large proportion of service users (ten out of seventeen) identified needing 'low-level' practical assistance in the home from the social rehabilitation project e.g. vacuuming, general cleaning They said this not only assisted their recovery by maintaining personal and home care when they were physically incapacitated, but it helped restore their morale in a situation of social isolation: "I was in quite a lot of pain also I was very depressed . . . it was a wonderful help which got me through a very difficult time. I had no family or close friends" (Project C, p81).</p> <p>Although direct home care provision didn't fit the 'classic' social rehabilitation service model (focusing on service users gaining access to social networks and assisting service users to undertake tasks themselves gradually), project co-ordinators recognized that it was in service users' interests to meet this need, and accepted it as integral to the social rehabilitation service. They also appreciated</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>Describe intervention - The authors do not provide a clear description of the 5 projects. However, pieced together from the paper, the projects, as a whole can be described as: 'providing feedback on older service users' views and experience related to social care social care following hospital discharge. Second, the HACSR projects in question were primarily framed in terms of enhancing older service users' engagement with social networks and the exchange of social support. Their explicit brief was to provide social rehabilitation as an integral part of social care after hospital discharge. The social rehabilitation approach aims to provide: "Programmes of time-limited intervention to help them (service users) restore confidence and skills lost through injury, bereavement or other trauma or loss and to</li> </ul>	<p>that it could be a prerequisite for service users being able to engage in social contact outside their home –</p> <p>"Quite often people say, 'The thing I would most like help with is cleaning, because then I have got a bit more time perhaps to go out'...How the home looks to some people is so important, it gives them the confidence to face the world again" (Project C, p81).</p> <p><b>Advocacy to assist access to material and social resources:</b> There were several examples in which service users needed social care project workers to act as advocates in negotiations with key organizations and networks, to obtain material and social resources important to their health and well-being, for example, help obtaining benefits.</p> <p>Example - 1 service user had been expected to go into residential care after leaving hospital. However, she didn't want this as she'd always been very independent. She had dysphasia (a profound hearing impairment) and some degree of cognitive impairment when tired. She could not manage paying bills and often forgot what she had gone for when out shopping: "The SR worker accompanied the service user to the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>focus upon motivation and the restoration of valued social roles and networks” (Le Mesurier 2003 p7). ‘Therefore, the issue of access to social networks was central to practice’ (p77). Also, older service users were encouraged to specify as precisely as possible their chosen objectives for the social rehabilitation service.</p> <ul style="list-style-type: none"> <li>• Delivered by - Mainly volunteers although they were supplemented by paid workers who provided the social care input.</li> <li>• Delivered to - Older people following discharge from hospital.</li> <li>• Duration, frequency, intensity, etc. – 1 to 1 and a half hours weekly (not that this is for the social rehab 'element). Six to 8 weeks in duration.</li> <li>• Key components and objectives of intervention - The objective, although not explicitly stated as such is to</li> </ul>	<p>bank and facilitated discussion between her and the bank manager about how paying the bills could be managed. Obtaining food was also problematic. The voluntary agency’s shopping service offered a solution, but involved using the telephone. As well as finding suitable adaptations for the phone, the SR worker arranged for a worker associated with the shopping service to be trained to understand the service user on the phone. She also negotiated arrangements for the service user to telephone at her preferred times. Eventually the service user was able to audio-order and use aide memoires concerning what she wanted to purchase” (Project C, p82).</p> <p><b>Social care as educational assistance:</b>  Unlike advocacy, educational assistance to help service users acquire skills which they have never needed before, or re-acquire skills forgotten or ‘lost’ through lack of confidence or practice, is not conventionally provided either directly by social workers or through services arranged by them. However to overcome barriers to social life, this educational assistance is very important.</p> <p>Example - "One service user wanted to resume visits to the betting shop which had been the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>provide social rehabilitation as an integral part of social care after hospital discharge.</p> <ul style="list-style-type: none"> <li>• Location/place of delivery - People's homes, with visits to outside locations as desired by the service user (e.g. town, betting shop).</li> </ul>	<p>hub of his social life before hospitalisation. However, his seriously impaired mobility necessitated use of a taxi and he had no experience of using taxis. The volunteer provided basic instruction and soon the service user was able to order taxis and resume his former life” (Project C, p83). In several cases, service users needed reassurance and encouragement from project workers to begin or resume using mobility aids:</p> <p>Example - "One service user had a mobility scooter but was too nervous to drive it. She and the project worker agreed that the worker would walk alongside her for a couple of trips. After this the service user was able to drive the scooter independently” (Project A, p83).</p> <p><b>Addressing psychological barriers to entry to social networks:</b> Some service users needed assistance to tackle psychological barriers to entry to social networks. Meeting these requirements needed sensitive, painstaking, interpersonal contact on the part of the workers. The processes identified by the study embodied a task-centred approach in that it included the agreement of clearly defined goals reflecting service users’ priorities, and manageable stages of activity to reach such</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>goals.</p> <p>Example - "After the death of her husband, 1 service user could not go outside without holding someone's arm. Ultimately the goal was for her to feel confident enough to go out on her own, but the first task towards this was just walking down the drive without linking arms. The next goals were walking from 1 lamp-post to another, then walking to the local shops, in each case accompanied, but not linking arms. Eventually the woman had acquired enough confidence to go on holiday with her family" (Project E, p84).</p> <p><b>Access to health care organisations and networks:</b> Alongside assistance to access social networks more generally, older service users also required assistance to access specialized health care providers. 1 volunteer provided personal support to ensure that a service user kept up his exercise programme following cardiac surgery and another service user with impaired mobility and sensory impairment was accompanied to the dentist to commence regular dental treatment, with the project worker facilitating her communication.</p> <p><b>Choice:</b> Service users appreciated the degree</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>of choice in terms of objectives and service delivery offered by the project. The Social Rehabilitation approach was anti-ageist, resisting threats to well-being from assumptions that older service users would fit into 'standard issue' community care services. 1 woman had been encouraged to go to a day centre following discharge. However the day centre transport arrived too early - she wanted to get up later in the day (a privilege of being retired). Also, she'd rather go to the park. The social rehabilitation worker therefore took her electric wheelchair with them to the park and accompanied her on walks, building to a point where she'd be able to go out independently.</p> <p><b>Friendship:</b> Service users' appreciation of the quality of interpersonal contact that volunteers offered radiated from their feedback, "A real person comes into your home and becomes your friend" (Project A, p85).</p> <p>The prime aim of this project was not to provide a befriending service, but to facilitate access to social networks. However, in the context of relative social isolation, the elements of contact with a friend, provided by interaction with project workers, were particularly valued by service users.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p><b>Time:</b> Service users were happy with the frequency and length of visits, averaging 1 to 1½ hours, weekly, they complained that the duration of the HACSR service—6 to 8 weeks, on average—was too short. Their first reason for this was that they had still felt unable to cope without assistance when the service ended. Second, service users regretted the loss of the quality of friendship that had characterized personal contact with project workers, at the end of the relatively short timescale of the project.</p>	

**4. Mitchell F, Dobson C, McAlpine A et al. (2011) Intermediate care: Lessons from a demonstrator project in Fife. Journal of Integrated Care 19(1): 26-36**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The objectives of the demonstrator pilot were to further develop the Fife-wide intermediate care system, to increase capacity, flexibility and responsiveness.</p>	<p><b>Participants:</b></p> <ul style="list-style-type: none"> <li>• Service users and their families, partners and carers.</li> <li>• Professionals/practitioners - Eighteen survey respondents.</li> </ul> <p><b>Sample size:</b> Twelve service users and 18 staff.</p> <p><b>Intervention:</b></p>	<p><b>Findings – effectiveness:</b> Thirty-four patients were assessed as part of the extended access hours project. As a result, 11 hospital patients were supported to go home in the out-of-hours period, and 3 clients were supported to remain at home following a medical emergency, which prevented hospital admission.</p> <p><b>Narrative findings – qualitative and views and experiences data:</b></p>	<p><b>Overall assessment of internal validity:</b> -</p> <p><b>Overall assessment of external validity:</b> ++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>The aim of the patient interviews was to increase service user involvement in the development of the intermediate care system. The aim of the staff survey is to report on staff experience of the extended access service.</p> <p><b>Methodology:</b> Qualitative study - Face to face service user interviews and a staff survey.</p> <p><b>Source of funding:</b> Government - The Scottish government funded the demonstrator project, which included the interviews reported here.</p>	<ul style="list-style-type: none"> <li>Describe intervention - The demonstrator project increased the availability of access to the existing intermediate care services in 1 locality in Fife. The extended access arrangements were focused on the integrated response team (IRT). IRT provides a rehabilitation service to support people after discharge from acute hospital, or prevent inappropriate admissions to hospital. This service is provided in the patient's home over a 14-day period. A multidisciplinary team, from health and social work, provides assessment from 09.00–17.00 Monday–Friday, and generic rehabilitation assistants provide daily support between the hours of 08.00 and 22.00 every day. The availability of professional staff to provide assessment and care management was extended to Wednesday, Thursday and Friday evenings</li> </ul>	<p><b>Personalised care</b> - All the patients questioned felt that the service listened to them, and that care and support were provided at a time and a frequency that suited them. The responses indicated that the team delivered a flexible, person-centred service that treated patients with respect.</p> <p><b>Feeling safe</b> - All patients said that they felt safe when receiving the intermediate care service, and continue to feel safe, "I preferred to be at home and felt very safe at home. I felt safe knowing someone was coming in to help me" (p30).</p> <p><b>ADL improvements</b> - The results provide strong evidence that the service enabled patients to return to their previous level of ability in activities of daily living. Patients commented that they felt more confident in their ability to cope at home.</p> <p><b>Social activities</b> - All the patients had returned to the social activities that they had managed before their recent hospital admission, and all those interviewed were managing to get out of their home.</p>	<p><b>Overall validity rating:</b> -</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>until 19.00, and on Saturdays from 09.00–14.00. These times were based on information from the local hospital Accident and Emergency Department and data on week-end referral patterns to community health services provided by the primary care emergency service.</p> <ul style="list-style-type: none"> <li>• Delivered by - A multidisciplinary team, from health and social work, provides assessment from 09.00–17.00 Monday– Friday, and generic rehabilitation assistants provide daily support between the hours of 08.00 and 22.00 every day.</li> <li>• Delivered to - 'Frail older people with complex needs'.</li> <li>• Duration, frequency, intensity, etc. - Integrated Response Teams provide a rehabilitation service to support people after discharge from acute hospital, or prevent inappropriate admissions to hospital. This service is provided in the</li> </ul>	<p><b>Staff experience</b> - Staff were asked what they were able to provide during the extended access hours that could not be done within standard working hours. The responses indicated that arranging afternoon discharges from hospital and discharges on Saturdays, and the ability to complete professional assessments during these extended hours, enabled more flexibility in the intermediate care system (p30-1).</p> <p>Positive comments were made about the advantages of staff working across teams and being able to follow patients through their care journey. Negative comments referred to the difficulties in working across organisational boundaries and being unfamiliar with operational systems.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>patient's home over a 14-day period.</p> <ul style="list-style-type: none"> <li>Location/place of delivery - People's own homes.</li> </ul> <p><b>Outcomes measured:</b>  <u>Service outcomes</u> - Destination after assessment (admission avoidance and hospital discharge) - although it should be noted that these outcomes are not linked to the interview participants.</p>		

**5. Townsend J, Godfrey M, Moore J (2006) Careful thoughts: Recognising and supporting older carers in intermediate care. Research Policy and Planning 24(1): 39-52**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The aim of the study was to explore the nature of informal caring relationships and interactions between service users, carers and intermediate care services.</p>	<p><b>Participants:</b> Service users and their families, partners and carers - People using intermediate care services and their carers.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>Age - The mean age of service users was 79 years. Carers ranged in age from 29-82 years, with 14 aged over 60.</li> </ul>	<p><b>Narrative findings – qualitative and views and experiences data:</b></p> <p>Five types of caregiving relationships were identified:</p> <ol style="list-style-type: none"> <li>1) The temporary carer.</li> <li>2) Reciprocal supporter through gentle decline: "Constance is a wonderful person; she's always done everything for us. I tell her we take a copy from her...I go down every day and ask if there</li> </ol>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Methodology:</b> Qualitative study. This was a qualitative study of in-depth interviews with people using intermediate care services and their carers.</p> <p><b>Country:</b> UK.</p> <p><b>Source of funding:</b> Government - The study is funded by the Department of Health and the Medical Research Council.</p>	<ul style="list-style-type: none"> <li>• Sex - Service users were predominantly female (the exact number is not reported). The sex of carers is not reported.</li> <li>• Ethnicity - The ethnicity of service users is not reported. One carer was of African Caribbean origin and the remainder were white British.</li> <li>• Religion/belief - Not reported.</li> <li>• Disability - Not reported.</li> <li>• Long term health condition - Not reported.</li> <li>• Sexual orientation - Not reported.</li> <li>• Socioeconomic position - Not reported.</li> </ul> <p><b>Sample size:</b> Not clear. This is not made explicit, however, 64 service users were interviewed - as were 21 carers.</p> <p><b>Costs?</b> No. There is no information on costs.</p>	<p>is anything to do but I don't do anything now. I just keep her company to walk out, keep her on her feet but some days she's tired out" (p43).</p> <p>3) Shared disrupted lives. 4) Long term carer. 5) Caregiver as care-receiver: "It was unbelievable...my husband had collapsed really because he realised how dependent he was on me...when I walked in with a sling...It affected him dreadfully...They organised everything ...helped us get up, dressed, organised a meal...You don't realise what you can't do when you have lost the use of your right hand - nothing. Looking back, we'd have been in care..." (p44).</p> <p>Themes relating to service responses within intermediate care and in handing over to longer-term support were also identified:</p> <p>1) Intermediate care. 2) Getting the service user going again: "I said I can't have him home until he can walk because I'm nearly 80. I couldn't move him to the toilet" (p45). 3) Reassurance and confidence building. 4) Personal communication "The nursing home really was a wonderful place... I went in at different times - popped in during the morning or the afternoon and there was the same</p>	<p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>care...Once or twice I had a word with the nurses just to make sure she wasn't covering anything up because if you ask Constance how she is, she'll always say, 'Fine'" (p46).</p> <p>5) Carer education.</p> <p>6) Baton-passing to mainstream services "They never asked me about things - just told me ways that they could make it easier for me, like the pension being put in the bank" (p47).</p>	

## Review question 1 – Findings tables – Health, social care and other practitioners' views and experiences

### 1. Chouliara N, Fisher RJ, Kerr M et al. (2014) Implementing evidence-based stroke Early Supported Discharge services: A qualitative study of challenges, facilitators and impact. *Clinical Rehabilitation* 28: 370-7

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> To report the views of health professionals and commissioners working with a stroke Early Supported Discharge service in relation to the impact of the service and the factors which '...</p>	<p><b>Participants:</b> Professionals/practitioners - Practitioners, managers and commissioners in roles which led to involvement with 1 of the 2 Early Supported Discharge services. This included practitioners involved in delivery of the services, individuals involved in commissioning or management of the services, and</p>	<p><b>Narrative findings – qualitative and views and experiences data:</b> The interviews are described by the authors as semi-structured and aimed to cover 4 main topics. These were - the nature of the participants' involvement with the service, factors which had helped or hindered implementation, impact of the service, and suggested improvements. The authors report '... considerable overlap in the views of respondents' (p372).</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p>The lack of detail in relation to contexts and participants, and the fact that data was only collected by 1 method means that</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>facilitate or impede the implementation of the service' (p370).</p> <p><b>Methodology:</b> Qualitative study - semi-structured interviews.</p> <p><b>Country:</b> UK- Nottinghamshire.</p> <p><b>Source of funding</b> Government - National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care for Nottinghamshire, Derbyshire and Lincolnshire.</p>	<p>hospital based staff who made referrals to the services.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Not reported.</li> <li>• Sex - Not reported.</li> <li>• Ethnicity - Not reported.</li> <li>• Religion/belief - Not reported.</li> <li>• Disability - Not reported.</li> <li>• Long term health condition - Not reported.</li> <li>• Sexual orientation - Not reported.</li> <li>• Socioeconomic position - Not reported.</li> </ul> <p><b>Sample size:</b> n=35 (Site A n=17; Site B n=18). Participants are described as Early Supported Discharge stakeholders and their job roles are categorised as the following:- commissioning (Site A n=2; Site B n=4); service management (Site A n=4; Site B n=2); Early Supported Discharge Team Lead (Site A n=1; Site B n=2); Early Supported Discharge team member (Site A n=4; Site B</p>	<p><b>Facilitators –</b> The authors report that 5 participants from each site felt that maintaining a balance between flexibility and specificity with regard to eligibility criteria was an important means of ensuring that referrals were appropriate: “I think the criteria are good because they are not too defined or too loose; I think there are very few inappropriate people that come through” (Stroke Physician 1; p372).</p> <p>Most participants also felt that the service should be adaptable to the context of local healthcare and be responsive to the variable level of need which exists: “No 2 stroke cases are ever going to be the same; our systems need to be reflective of that” (Commissioning 23; p372).</p> <p>The authors note that in recognition of this the team at Site A used severity of disability as an eligibility criterion but prioritised ‘... the safety of the home environment and the identification of specific rehabilitation goals ...’ (Authors, p372).</p> <p>The authors report that a number of participants from Site A felt that it was important to be flexible in relation to the timescale of the intervention because rigidly adhering to 6</p>	<p>it is not possible to award a higher quality rating.</p> <p><b>Overall assessment of external validity:</b> +</p> <p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>n=4); Stroke Physician (Site A n=1; Site B n=1); Acute Stroke Unit staff (Site A n=5; Site B n=2); Rehab Stroke Unit staff (Site A n=0; Site B n=3).</p> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Stroke Early Supported Discharge services. Describe intervention - Little detail is provided in relation to the intervention, however in there discussion of relevant literature the authors note that Early Supported Discharge services are ‘... delivered by coordinated, multidisciplinary teams ...’ (p371). The team at Site A can refer service users to a jointly managed community stroke team; however there is no community stroke team linked to Site B.</li> <li>• Delivered by - Both teams are described as multi-disciplinary and specialist. The team at Site A was composed of Stroke Physician; Physiotherapist;</li> </ul>	<p>weeks was unnecessary in some cases and could delay new referrals.</p> <p>The authors also note that at Site B the intervention was sometimes extended in order to ‘compensate’ for the fact that the region did not have a specialised community based stroke rehabilitation service.</p> <p>A significant number of participants felt that the role of rehabilitation assistants (usually Assistant Practitioners or Rehabilitation Support Workers) had improved the service because allowing these staff members to deliver routine and more repetitive exercises enabled more senior staff to focus on more specialised elements of care: “It’s about being able to break down the role and make sure that the right skilled person is doing the right part of the intervention” (Early Supported Discharge Team Lead, 3; p373).</p> <p>The authors note that at Site A; Assistant Practitioners had greater responsibility than Rehabilitation Support Workers and were able to “... progress rehabilitation goals or take over the care of less complex patients” (Authors, p373).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>Occupational Therapist; Speech and Language Therapist; Stroke Nurse; Mental Health Nurse; Social Worker; Assistant Practitioner; Rehabilitation Support Worker; and Administrative Support. The team at Site B was composed of Stroke Physician; Physiotherapist; Occupational Therapist; Speech and Language Therapist; Stroke Nurse; Clinical Psychologist; Rehabilitation Support Worker; Administrative Support. NB Details on the numbers of professionals working in each role are not provided.</p> <ul style="list-style-type: none"> <li>Delivered to - Individuals who have experienced stroke. The study does not provide any details in relation to service users other than noting that each site used a range of eligibility criteria including 'Barthel Index <math>\geq</math> 14/20; transfer independently or with assistance of one (+/- equipment); sufficiently</li> </ul>	<p>The authors also report that participants felt that developing strong links with other services was vital to the success of the service; with professionals at Site B noting that this had enabled them to identify appropriate referrals:</p> <p>"We've really endeavoured to build up a good relationship with the different organisations and I think the better that is, the better the team runs because you are getting referrals and good understanding" (Early Supported Discharge Team Lead, 29; p373).</p> <p>Participants also identified a number of methods of improving communication and collaboration between services. Suggestions included joint meetings and training, as well as staff rotations: "We could have some rotational element between staff so you can really share that sort of approach and the learning" (Early Supported Discharge Team Lead, 3; p373).</p> <p><b>Challenges</b> - The authors report that hospital staff were sometimes viewed as being unwilling to make referrals to Early Supported Discharge services which was felt to result in unnecessarily long stays in hospital. Hospital staff voiced scepticism regarding the service, which some attributed to a lack of knowledge in</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>medically fit to be managed at home; identified achievable rehabilitation goals' (p371). The main source of referrals for Site A was an acute hospital with a hyperacute stroke unit and linked specialist stroke rehabilitation wards. The main source of referrals for Site B was an acute hospital with an acute stroke unit only. Site A does not accept referrals from other sources, however Site B accepts referrals from a community hospital with a specialist stroke rehabilitation ward.</p> <ul style="list-style-type: none"> <li>• Duration, frequency, intensity, etc. -Each team is described as providing 1-2 interventions per day for a total of up to 6 weeks (8am to 6pm, 7 days per week, patient caseload of 16).</li> <li>• Key components and objectives of intervention - Not reported.</li> <li>• Content/session titles - N/A</li> </ul>	<p>relation to its content and the outcomes it aimed to effect:</p> <p>"Just getting a bit more understanding of what the content is so that we can decide that Early Supported Discharge is in the best interests of the patient" (Acute Stroke Unit Staff, 8; p374).</p> <p>There was a lack of consensus between respondents in relation to when the decision to refer to Early Supported Discharge services should be made. Two participants at Site A felt that the decision should be made almost as soon as the person is admitted to an acute unit, whilst 4 other professionals at this site felt that making this decision even in the first 2 weeks after admission to an acute unit was problematic because recovery was still taking place.</p> <p>The authors report that a number of commissioners felt that the position of Early Supported Discharge services in relation to other services in the stroke care pathway needed to be clarified:</p> <p>"To be honest I am bit foggy about where Early Supported Discharge sits alongside intermediate care and re-enablement and how</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Location/place of delivery - Partly delivered in the participant's own home.</li> </ul>	<p>these are married up.” (Commissioning, 23, p374).</p> <p>A significant proportion of respondents are reported to have identified difficulties in involving social care as a major barrier to the early discharge process. Team members at Site B (which did not include a Social Worker) reported that they had had to stop taking referrals due to these delays in arrangements of care: “Patients were bottlenecking up at the other end because their care packages wouldn't be ready; at 8 weeks we'd still got these patients” (Service Management, 18, p374).</p> <p>The authors report that most professionals from Site A felt that having a Social Worker on the team helped to address these difficulties. Participants working at both sites also identified the challenges resulting from a lack of community based specialised services for individuals with more complex needs or greater levels of disability. This sometimes led to inappropriate referrals: “Sometimes they think we are social care and we are not....we have done things above and beyond what we are expected to do” (Early Supported Discharge Team Member, 10, p374).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Professionals at Site B felt that this was a significant gap in the stroke care pathway: “Patients who need more intensity than an outpatient programme could provide or those for whom home environment is more suitable, fall into a black hole at the moment” (Early Supported Discharge Team Lead, 29, p374).</p> <p>A number of respondents also highlighted the issue of duplicated assessments between services and suggested that information-sharing between hospitals and Early Supported Discharge services needed to be improved.</p> <p><b>Impact of Early Supported Discharge services</b> - The authors report that the majority of stakeholders across both sites viewed Early Supported Discharge as a positive service which could reduce hospital stays without hindering rehabilitation: “Patients are able to come out of the hospital sooner which is what they prefer, and they are able to continue specialist rehabilitation in their own environment...so they can have some of their normal life going on and have their family involved” (Early Supported Discharge Team Lead, 3, p374).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Respondents at Site B are reported to have identified Early Supported Discharge services as a means of addressing the gap in community based rehabilitation; whilst a number of professionals based at Site A felt that the service had improved links between acute and community stroke services:</p> <p>“Transfer between the services has improved and works in a much more seamless way” (Service Management, 4, p374).</p> <p>A large proportion of respondents emphasised the importance of community based specialised stroke care as a means of maximising recovery and ensuring continuity of care. Providing specialised care in the community was seen by many participants as a defining feature of Early Supported Discharge services:</p> <p>“Having the knowledge to deal with stroke patients is what sets the service aside from other community services” (Acute Stroke Unit Staff, 16, p375). Many participants are reported to have identified home based rehabilitation as a useful model of care because it enables more accurate assessments of the individual in their own environment and has greater scope to be tailored to the needs of the individual:</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>“It is less about a body in a bed that needs a bit of fixing; to me, it feels more of a holistic service; just being in peoples’ houses, seeing what problems they actually have and adapting the service around that” (Early Supported Discharge Team Member, 30, p375).</p> <p>Participants are also reported to have felt that it was appropriate for Early Supported Discharge services to attempt to address any emotional or cognitive difficulties which a service user was experiencing as these may not have been apparent before discharge: “Even people that have minimal physical impairments can be really anxious because their whole life has changed” (Early Supported Discharge Team Lead, 29, p375).</p> <p>However, fully addressing these issues was felt to be unlikely given the short timescale of the service. A small number of commissioners felt that the evidence base in relation to the effectiveness of Early Supported Discharge services needed to be strengthened, particularly in an economic climate which demands evidence of improved outcomes. It was suggested that this should determine whether Early Supported Discharge services</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		were: "... the most efficient and effective way of providing rehabilitation and helping patients make the best of their recovery" (Commissioner, 34, p375). 1 professional commented that communication was also important in this respect: "We need more info on the outcomes of the intervention...they need to demonstrate what they can offer...to sell themselves really" (Acute Stroke Unit Staff, 16, p375).	

**2. Glasby J, Martin G, Regen E (2008) Older people and the relationship between hospital services and intermediate care: Results from a national evaluation. Journal of Interprofessional Care 22: 639-49**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> 'To explore the views of intermediate care leads on the benefits and challenges of implementing intermediate care policy' (p642).</p> <p><b>Methodology:</b> Qualitative study -</p>	<p><b>Participants:</b> Professionals/practitioners - Key professionals involved in the delivery, management and planning of intermediate care services across 5 sites.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Not reported.</li> <li>• Sex - Not reported.</li> <li>• Ethnicity - Not reported.</li> <li>• Religion/belief - Not reported.</li> <li>• Disability - Not reported.</li> </ul>	<p><b>Narrative findings – qualitative and views and experiences data:</b></p> <p><b>'Intermediate care as part of a spectrum of services and as a positive alternative to hospital' (p642)</b> - The authors report that many respondents (working in a range of settings and including both managers and clinicians) noted that intermediate care had developed as a response to pressures on acute care and the recognition that there was a '... need to do things differently ...' (Authors, p642).</p>	<p><b>Overall assessment of internal validity:</b></p> <p>+</p> <p>Lack of detail on context and participants; and sampling of 'key' managers and practitioners.</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>Interviews and focus groups.</p> <p><b>Country:</b> UK. Five sites across the UK (including both rural and urban areas - no further details reported in this study).</p> <p><b>Source of funding</b> Government - Department of Health and the Medical Research Council.</p>	<ul style="list-style-type: none"> <li>• Long term health condition - Not reported.</li> <li>• Sexual orientation - Not reported.</li> <li>• Socioeconomic position - Not reported.</li> </ul> <p><b>Sample size:</b> Sample size - Interviews = 61 participants; focus groups = 21 participants (across all 5 sites). No detail in relation to participants is provided except to note that the study draws on interviews with stakeholders working in acute care, intermediate care, primary care, and social services; and focus groups with frontline staff.</p> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Intermediate care. The study reports on interviews and focus groups with key managers and practitioners working in intermediate care across 5 sites. It is not clear which models of intermediate care are provided at these sites.</li> </ul>	<p>Intermediate care was seen by respondents as a positive development which fosters choice, and improves quality of life and independence which was more difficult to achieve in acute services which are often under pressure and tend lead to have dependency culture. The authors emphasise that respondents felt that the success of intermediate care depended on the extent to which it offered choice and flexibility to older people as part of a wide range of care for older people.</p> <p>The authors also report that respondents felt that a service which enabled older people to regain their independence in a non-acute setting was valuable and enabled a more accurate assessment of an individual's level of dependency.</p> <p><b>“Difficulties in the relationship with acute care: issues for hospital staff” (p643)</b> - The authors report that some respondents felt that intermediate care services had in some instances been set up too rapidly and with only minimal input from hospital staff. Others felt that intermediate care the latest in a line of new projects that drained funding and shifted the focus from the importance of good practice:</p>	<p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Describe intervention - No details are provided on the services delivered at each site.</li> <li>• Delivered by - Not reported.</li> <li>• Delivered to - No details are provided on the service users served by each site however the focus of the paper is intermediate care provided to older people.</li> <li>• Duration, frequency, intensity, etc. - Not reported.</li> <li>• Key components and objectives of intervention - Not reported.</li> <li>• Content/session titles - N/A</li> <li>• Location/place of delivery - Not reported.</li> </ul>	<p>“I’ve been around far too long, I’ve seen so many new schemes come and go at the expense of good sound practice . . . [Sometimes it’s not because existing schemes aren’t working well, but because] the government likes to have new money going to new schemes and these new schemes [are] at the expense of [existing] good practice” (Respondent at site 2, p643).</p> <p>Some respondents are also reported to have been concerned that intermediate care represented a lower quality model of care and that services had been implemented before a sufficient evidence base had been developed.</p> <p>There was disagreement regarding the impact which intermediate care services could have on acute resources, with some respondents suggesting that clinicians working in hospitals may focus on acute care only and therefore ‘... lose sight of the whole person ...’ (Authors, p643).</p> <p>In contrast, other respondents are reported to have felt that this was ‘... a more appropriate use of expensive acute capacity’ (Authors, p643).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Respondents are also reported to have suggested that intermediate care services are seen as detached from mainstream services and that this perceived separation, coupled with hospital staffs and GPs poor understanding of intermediate care itself can resulted in low uptake.</p> <p>Although the authors note that there had been attempts to promote intermediate care locally, respondents reported that the service was still unfamiliar to many professionals: "I just think people don't think about it naturally as it is fairly new. Services have been limited and where they are they are probably working at capacity because they are so limited so thinking of a route through intermediate care as an alternative to admitting somebody or discharge them into long-term care, people just don't think about it" (Respondent at Site 2, p644).</p> <p>Other reasons for the perceived separation between mainstream services and intermediate care included eligibility criteria which were seen as too restrictive and allowed patients to be 'cherry-picked': "Well the units...do develop criteria, don't they, because they have to safeguard themselves by having so many exclusions that actually they become almost</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>impossible to use because busy clinicians can't maintain all the exclusion criteria at their fingertips. And if you refer and are rejected, next time you see a case you're going to think well, we'll do it as we always used to do" (Respondent at Site 1, p644).</p> <p><b>'Difficulties in the relationship with acute care: issues for intermediate care staff'</b> (p643) – Some respondents are reported to have felt that staff in acute settings were slow to adapt to new services, were uncomfortable referring to intermediate care because they perceived that this meant loss of control over 'their' patient, and had little knowledge about services which were available (which the authors note is exacerbated by regular changes in staffing):</p> <p>"No I don't think safety is a problem, no. They just, I think these particular 2 [doctors] do not want to lose control of their patients. I think they see it as a threat, their patients going to somebody else, to a different Consultant" (Respondent at Site 1, p644).</p> <p>"I think the other thing is that I would like to see is that my colleagues in the hospital setting . . . feel more integrated with the intermediate care</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>set up, which they don't at the moment . . . They don't understand what is out there and it is just so difficult to keep people up to speed with new developments and changes" (Respondent at Site 5, p 644).</p> <p>Respondents were also concerned that hospital staff saw intermediate care solely as a means of reducing pressure on acute care rather than a service which was appropriate for some but not all patients:</p> <p>"[We get inappropriate referrals, particularly when there's] a bed panic, like there is today, and everybody will be told to go through the ward and find any patients and there will almost be a blanket referral [to intermediate care] for virtually anybody who is vaguely upright" (Respondent at Site 1, p645).</p> <p>"I personally think we are perceived as someone that can empty a hospital bed and not as a continuation of the care" (Respondent at Site 5, p645).</p> <p>The authors report that intermediate care staff sometimes felt under pressure to take referrals, including those which were inappropriate, as a means of ensuring that other professionals</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>accepted the new service:</p> <p>"There is a pressure to use Intermediate Care services for things not fit for purpose. We are already being asked to put people in Intermediate Care places where there actually is not an Intermediate Care element to that. It is to get this person out of acute hospital bed" (Respondent at Site 2, p645).</p> <p>The authors note that overall, '... concerns from community staff about the dominance and practices of acute services were a recurring theme' (Authors, p645). They also note that the feeling that intermediate care services could become a '... a dumping ground for secondary care ...' (respondent at site 1, p646) was common. Suggested solutions to some of the concerns raised by respondents included: greater involvement of geriatricians in intermediate care as a means of assuaging hospital staffs concerns regarding the quality of care; joint review of eligibility criteria, rotational posts, greater information and publicity in relation to services as well as more proactive work by intermediate care staff to identify potential patients and greater in-reach in acute settings (e.g. full involvement in discharge meetings).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>The authors suggest that these solutions were all underpinned by the sense that there needed to be a cultural shift if acute services and intermediate care were to work effectively together:</p> <p>"I think the interface between primary and secondary care is a concept and it doesn't function really, other than as a place of passing people from one to the other by paper, or e-mail or whatever. I think our view is that you will only get a real interface if it's a working environment where there is some sort of working link between people in the community and people in hospital so that you can start to develop an understanding between clinicians of what is possible and so you can have some commonality about risk sharing and risk management . . ." (Respondent at site 2, p 646)</p>	

## Review question 1 – Findings tables – additional effectiveness data

1. Aimonino N, Tibaldi V, Barale S et al. (2007) Depressive symptoms and quality of life in elderly patients with exacerbation of chronic obstructive pulmonary disease or cardiac heart failure: Preliminary data of a randomized controlled trial. *Archives of Gerontology and Geriatrics* 44 (Suppl. 1): 7-12

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> To evaluate mortality, functional, cognitive, affective status in elderly patients (&lt;75 years of age) with chronic obstructive pulmonary disease or acute congestive heart failure when treated at home or in a general ward after admission to emergency department.</p> <p><b>Methodology:</b> Randomised controlled trial.</p> <p><b>Country:</b> Not UK. Italy.</p> <p><b>Source of funding:</b> Not reported.</p>	<p><b>Participants:</b> Service users and their families, partners and carers - chronic obstructive pulmonary disease or acute congestive heart failure patients.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - mean age 81.7±8.0 years.</li> <li>• Sex - not reported.</li> <li>• Ethnicity - not reported.</li> <li>• Religion/belief - not reported.</li> <li>• Disability - all elderly and functionally impaired.</li> <li>• Long term health condition - chronic obstructive pulmonary disease or acute congestive heart failure, with comorbidities.</li> <li>• Sexual orientation - not reported.</li> <li>• Socioeconomic position - not reported.</li> </ul> <p><b>Sample size:</b></p>	<p><b>Statistical data - service user related outcomes -</b></p> <p>Mortality: No significant difference between geriatric home hospital service and general medical ward.</p> <p>Depression scores: From baseline to 6 months follow-up geriatric home hospital service 14.25 to 12.44 (reduction of 1.81) vs. general medical ward 12.81 to 12.68 (reduction of 0.13) (significant, no p values given.)</p> <p>Nottingham Health Profile - quality of life: From baseline to 6 months follow-up geriatric home hospital service reduced from 18.89 to 16.79 (improved score of 2.1) vs. general medical ward reduced from 16.52 to 16.27 (improved score of 0.25) (significant, no p values given). NB. Higher scores correspond to greater number and more severe problems.</p> <p><b>Statistical data - service outcomes –</b></p> <p>Hospital readmission at 6 months: A lower readmission rate in geriatric home hospital</p>	<p><b>Overall assessment of internal validity:</b></p> <p>-</p> <p><b>Overall assessment of external validity:</b></p> <p>+</p> <p><b>Overall validity rating:</b></p> <p>+</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Comparison numbers - General medical ward n=35. (16 chronic obstructive pulmonary disease; 19 congestive heart failure).</li> <li>• Intervention numbers - Geriatric home hospital service – n=38 (19 chronic obstructive pulmonary disease; 19 congestive heart failure).</li> <li>• Sample size – n=73.</li> </ul> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Geriatric home hospital service. Describe intervention - Geriatric home hospital service, operating since 1985, a home based intervention and a service that provides diagnostic and therapeutic treatments by health care professionals in patient's home. It is a multidisciplinary team, including geriatricians, nurses, physiotherapists, social workers and counsellors, also medical consultation.</li> <li>• Delivered by - Multidisciplinary team.</li> </ul>	<p>service 16.6% vs. general medical ward 26.6% (no p values given).</p> <p>Lengths of treatment (days): A longer length of treatment in geriatric home hospital service 22.3±10.8 days vs. general medical ward 12.6±8.5 days (significant, no p values given).</p> <p><b>Effect sizes:</b> Home hospital service vs. general medical ward: Activities of Daily Living (ADL): d=0.3258; 95% Confidence Interval -0.1364 to 0.788; Instrumental Activities of Daily Living (IADL): d=-0.4432; 95% CI -0.908 to 0.0216; Geriatric Depression Scale (GDS): d=0.2725; 95% CI -0.1888 to 0.7338; Nottingham Health Profile (NHP), a quality of life measure: d=0.2727; 95% CI -0.1886 to 0.734.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Delivered to - Chronic obstructive pulmonary disease and congestive heart failure patients.</li> <li>• Duration, frequency, intensity, etc. - not reported.</li> <li>• Key components and objectives of intervention - not reported.</li> <li>• Content/session titles - not reported.</li> <li>• Location/place of delivery - Geriatric homes where the participants stay.</li> </ul> <p><b>Comparison intervention:</b> General medical ward service in hospital.</p> <p><b>Outcomes measured:</b> Service user related outcomes –</p> <ul style="list-style-type: none"> <li>• Activities of Daily Living.</li> <li>• Instrumental Activities of Daily Living.</li> <li>• Mini Mental State Examination.</li> <li>• Geriatric Depression Scale.</li> <li>• Mini Nutritional Assessment.</li> </ul>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Acute Physiology and Chronic Health Evaluation.</li> <li>• Cumulative Illness Rating scale.</li> <li>• Nottingham Health Profile - quality of life.</li> <li>• Co-morbidity.</li> <li>• Mortality.</li> </ul> <p>Service outcomes –</p> <ul style="list-style-type: none"> <li>• Hospital readmission.</li> <li>• Lengths of treatment.</li> </ul> <p><b>Follow-up:</b> 6 months.</p> <p><b>Costs?</b> No.</p>		

**2. Bjorkdahl A, Nilsson AL, Grimby G et al. (2006) Does a short period of rehabilitation in the home setting facilitate functioning after stroke? A randomized controlled trial. Clinical Rehabilitation 20: 1038-49**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> To evaluate if 3 weeks of rehabilitation in the home setting of younger patients with stroke would improve activity more than ordinary</p>	<p><b>Participants:</b> Service users and their families, partners and carers - Young stroke patients.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Median age 53 years (range 27 to 64).</li> <li>• Sex - 44 men; 15 women.</li> </ul>	<p><b>Statistical data - service user related outcomes –</b> (NB. Effect sizes not reported by the authors. Effect sizes presented here were calculated by the review team.)</p> <p>Assessment of Motor Skills scores (AMPS): Both groups improved significantly from discharge to 1 year follow-up, no significant</p>	<p><b>Overall assessment of internal validity:</b> ++</p> <p><b>Overall assessment of external validity:</b></p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>outpatient rehabilitation at the clinic and facilitate the rehabilitation process.</p> <p><b>Methodology:</b> Randomised controlled trial.</p> <p><b>Country:</b> Sweden.</p> <p><b>Source of funding:</b> Not reported.</p>	<ul style="list-style-type: none"> <li>• Ethnicity - not reported.</li> <li>• Religion/belief - not reported.</li> <li>• Disability - not reported.</li> <li>• Long term health condition - All were stroke patients.</li> <li>• Sexual orientation - Not reported.</li> <li>• Socioeconomic position - Not reported.</li> </ul> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers - Control (day clinic group): n=29.</li> <li>• Intervention numbers - Intervention (home group), n=30.</li> <li>• Sample size - Total n=59.</li> </ul> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Home rehabilitation.</li> <li>• Describe intervention - The patients received 9 hours of training per week for 3 weeks after discharge from the rehabilitation ward, same as what was usually offered at the day clinic. In the home group family or friends and helpers</li> </ul>	<p>difference between the home group and the day clinic group.</p> <p>Improvement occurred at different times – The home group improved significantly from discharge to 3 weeks, no significant change in clinic group during the intervention.</p> <p>At discharge - home (n=30) - mean 1.45 (SD 0.99) vs. clinic (n=29) - mean 1.42 (SD 0.76). At 3 weeks - home (n=29) - mean 1.71 (SD 0.91) vs. clinic (n=29) - mean 1.52 (SD 0.71). At 3 months – home (n=28) - mean 2.02 (SD 1.08) vs. clinic (n=29) - mean 1.88 (SD 0.78). At 1 year - home (n=28) - mean 2.18 (SD 1.04) vs. clinic (n=29) - mean 2.28 (SD 0.94).</p> <p>Effect sizes of home group vs. day clinic group, using ordinal scale: AMPS Motor (logits) Cut-off 2.0: 3 weeks: d=0.2328; 95% Confidence Interval -0.2837 to 0.7493; 3 months: d=0.149; 95% CI -0.371 to 0.6691; 1 year: d=-0.101; 95% CI -0.6206 to 0.4186.</p> <p>Assessment of Process Skills scores: Overall, both groups improved significantly from discharge to 1 year follow-up, no significant difference between the home group and the day clinic group.</p>	<p>+</p> <p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>were involved and information was given to them and the patient about the stroke, its consequences and how to deal with them. An occupational therapist and a physiotherapist offered individually tailored training, based on the patient's needs and desires and with focus on activities in their natural context, a top-down approach. The content varied from personal care to shopping and trying out leisure activities. Since the training was taking place in the environment of the patient and according to needs at that specific day, no specific training equipment was used.</p> <ul style="list-style-type: none"> <li>• Delivered by - Occupational therapists and physiotherapists.</li> <li>• Delivered to - Stroke patients discharged home, and also to family or friends and helpers.</li> <li>• Duration, frequency, intensity, etc. - Nine hours of training per week for 3 weeks.</li> <li>• Key components and objectives of intervention - The intervention aimed to give</li> </ul>	<p>Improvement occurred at different times – The home group improved significantly between 3 months and 1 year.</p> <p>At discharge – home (n=30) - mean 1.00 (SD 0.73) vs. clinic (n=29) - mean 1.18 (SD 0.57).  At 3 weeks – home (n=29) - mean 1.26 (SD 0.75) vs. clinic (n=29) - mean 1.37 (SD 0.53).  At 3 months – home (n=28) - mean 1.23 (SD 0.64) vs. clinic (n=29) - mean 1.54 (SD 0.53).  At 1 year – home (n=28) - mean 1.55 (SD 0.76) vs. clinic (n=29) - mean 1.59 (SD 0.68).</p> <p>Effect sizes of home group vs. day clinic group, using ordinal scale, AMPS Process (logits)  Cut-off 1.0: Discharge: d=-0.2743; 95% CI -0.7871 to 0.2385; 3 weeks: d=-0.1694; 95% CI -0.685 to 0.3462; 3 months: d=-0.5285; 95% CI -1.0568 to -0.0002; 1 year: d=-0.0555; 95% CI -0.5749 to 0.4639.</p> <p>On both AMPS scales a significantly higher percentage of the patients in the home group than in the day clinic group reached the critical level of change at the end of the intervention, using the Kaplan-Meier curves.</p> <p>Functional Independence Measure (FIM) (motor) scores: Overall, both groups improved significantly from discharge to one-year follow-</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>support, information and training by both occupational therapists and physiotherapists in the home setting to transfer skills achieved in hospital into the home environment. A second aim was to describe the costs associated with the interventions.</p> <ul style="list-style-type: none"> <li>• Content/session titles – N/A.</li> <li>• Location/place of delivery – Home.</li> </ul> <p><b>Comparison intervention:</b> Day clinic (outpatient) rehabilitation. A multi-professional team (no details) offered training at the day clinic. The focus of the intervention in the day clinic group was more a bottom-up approach that focused on the training of deficits or components of function (impairment) in order to generate better ability to perform daily life activities.</p> <p><b>Outcomes measured:</b> Service user related outcomes –</p> <ul style="list-style-type: none"> <li>• The Assessment of Motor and Process Skills to assess IADL.</li> </ul>	<p>up. There were no significant differences between the 2 groups. Improvement occurred at different times. The clinic group improved significantly between 3 months and 1 year.</p> <p>At discharge – home (n=31) - mean 2.44 (SD 2.08) vs. clinic (n=30) - mean 2.38 (SD 1.70). At 3 weeks – home (n=30) - mean 2.83 (SD 2.05) vs. clinic (n=29) - mean 2.38 (SD 1.70). At 3 months – home (n=30) - mean 3.22 (SD 2.12) vs. clinic (n=29) - mean 2.86 (SD 1.90). At 1 year – home (n=29) - mean 3.14 (SD 2.07) vs. clinic (n=29) - mean 2.99 (SD 1.76).</p> <p>Effects sizes of FIM motor scores (logits): Discharge: d=0.0315; 95% CI -0.4705 to 0.5335; 3 weeks: d=0.2386; 95% CI -0.2736 to 0.7508; 3 months: d=0.1787; 95% CI -0.3328 to 0.6901; 1 year: d=0.0781; 95% CI -0.4368 to 0.593.</p> <p>Functional Independence Measure (social-cognitive) scores: Overall, both groups improved significantly from discharge to one-year follow-up. There were no significant differences between the 2 groups.</p> <p>Improvement occurred at different times. The clinic group improved significantly between discharge and 1 year.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• The Functional Independence Measure to assess dependence.</li> <li>• The Instrumental Activity Measure to assess dependence in everyday activity.</li> <li>• Thirty-metre walking test.</li> <li>• Neurological deficit using the National Institutes of Health Stroke Scale.</li> <li>• Screening for cerebral functions.</li> </ul> <p>Service outcomes –</p> <ul style="list-style-type: none"> <li>• Costs of home based rehabilitation and day clinic rehabilitation.</li> </ul> <p><b>Follow-up:</b> At 3 weeks, 3 months and 1 year.</p> <p><b>Costs?</b> Cost information.</p>	<p>At discharge – home (n=31) - mean 2.32 (SD 1.65) vs. clinic (n=30) - mean 2.43 (SD 1.57).  At 3 weeks – home (n=30) - mean 2.62 (SD 1.85) vs. clinic (n=29) - mean 2.94 (SD 1.57).  At 3 months – home (n=30) - mean 2.65 (SD 1.70) vs. clinic (n=29) mean 3.04 (SD 1.48).  At 1 year – home (n=29) mean 2.68 (SD 1.67) vs. clinic (n=29) - mean 3.29 (SD 1.50).</p> <p>Effect sizes of FIM social-cognitive scores (logits): Discharge: d=0.1986; 95% CI -0.3046 to 0.7018; 3 weeks: d=-0.1862; 95% CI -0.6978 to 0.3253; 3 months: d=-0.2444; 95% CI -0.7567 to 0.2679; 1 year: d=-0.3843; 95% CI -0.9037 to 0.1351.</p> <p>Instrumental Activity Measure (IAM) to assess dependence in everyday activity: Overall, both groups improved significantly from discharge to one-year follow-up, no significant differences between the 2 groups.</p> <p>At discharge – home (n=30) - mean -1.8 (SD 1.66) vs. clinic (n=29) - mean -3.2 (SD 1.10).  At 3 weeks – home (n=30) - mean 0.29 (SD 1.35) vs. clinic (n=29) - mean 0.08 (SD 0.99).  At 3 months – home - (n=30) - mean 0.54 (SD 1.47) vs. clinic (n=29) - mean 0.59 (SD 1.20).  At 1 year – home (n=29) - mean 0.70 (SD 1.63) vs. clinic (n=29) - mean 1.05 (SD 1.76).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Effect sizes of IAM (logits)  Discharge: <math>d=0.0991</math>; 95% CI <math>-0.4116</math> to <math>0.6098</math>; 3 weeks: <math>d=0.1769</math>; 95% CI <math>-0.3345</math> to <math>0.6883</math>; 3 months: <math>d=-0.0372</math>; 95% CI <math>-0.5476</math> to <math>0.4733</math>; 1 year: <math>d=-0.2063</math>; 95% CI <math>-0.7224</math> to <math>0.3097</math>.</p> <p>Thirty-metre walking test: Overall, both groups improved significantly from discharge to one-year follow-up, no significant differences between the 2 groups.</p> <p>Discharge 25 0.70 0.33 26 0.84 0.46  3 months 24 0.90 0.32 28 0.93 0.43  1 year 26 0.94 0.33 27 0.98 0.39</p> <p>At discharge – home (n=25) - mean 0.70 (SD 0.33) vs. clinic (n=26) - mean 0.84 (SD 0.46).  At 3 months – home (n=24) - mean 0.90 (SD 0.32) vs. clinic - (n=28) - mean 0.93 (SD 0.43).  At 1 year - home (n=26) - mean 0.94 (SD 0.33) vs. clinic (n=27) - mean 0.98 (SD 0.39).</p> <p>Effect sizes of Thirty-metre walking test:  Discharge: <math>d=-0.3486</math>; 95% CI <math>-0.9017</math> to <math>0.2046</math>; 3 months: <math>d=-0.0783</math>; 95% CI <math>-0.6237</math> to <math>0.4672</math>; 1 year: <math>d=-0.1105</math>; 95% CI <math>-0.6495</math> to <math>0.4284</math>.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		Total cost: Both groups received 27 hours of intervention in the 3 weeks.  Home: 1830 Euros Clinic: 4410 Euros (home group costs 42% of the clinic group.)	

**3. Björkdahl A, Nilsson AL, Sunnerhagen KS (2007) Can rehabilitation in the home setting reduce the burden of care for the next-of-kin of stroke victims? Journal of Rehabilitation Medicine 39: 27-32**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> To evaluate if an intervention with information about stroke and its consequences, as well as practical advice and training in the home setting reduces or affects the burden of care for next-of-kin.</p> <p><b>Methodology:</b> Randomised controlled trial.</p> <p><b>Country:</b> Sweden.</p>	<p><b>Participants:</b> Service users and their families, partners and carers - family carers, next-of-kin of stroke patients rehabilitating at home.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>Age - mean age of stroke patients 53 years; no info on carers. (NB. no. of husbands as carer responders to questionnaires: home group 6; day clinic group 3. no. of wives as carer responders to questionnaires: home group 12; day clinic group 12. no. of grown-up children responders to questionnaires: home group 0; day clinic group 2.)</li> </ul>	<p><b>Statistical data - family or caregiver related outcomes -</b></p> <p>Caregiver Burden Scale: Overall score of the 2 groups: No significant differences between the 2 groups. Maximum sum score of the Caregiver Burden Scale of 66, and reflects a definite burden on all questions. The median sum score of the sample was 27 (0–52) at 3 weeks, 21 (0–50) at 3 months and 19 (0–45) at the 1-year follow-up.</p> <p>Day clinic group: Significant change in Caregiver Burden Scale scores between 3 months and 1 year, suggesting a tendency to a lower burden on the 'general strain' index for the next-of-kin in the home group compared with the next-of-kin in the day clinic group at 3 weeks.</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> +</p> <p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Source of funding:</b> Government - The Swedish Research Council.</p>	<ul style="list-style-type: none"> <li>• Sex - Not reported for either patients or carers.</li> <li>• Ethnicity - Not reported for either patients or carers.</li> <li>• Religion/belief - Not reported for either patients or carers.</li> <li>• Disability - Not reported for carers.</li> <li>• Long term health condition - Not reported for carers of stroke patients. The sample of patients had a median score on the National Institute of Health Stroke Scale (NIHSS) of 5 (maximum score 36, the lower score the less deficit) and a median sum score of 76 (maximum score 91, which means total independence) on the Functional Independence Measure -motor scale at discharge from the rehabilitation ward. The groups did not differ in any aspect.)</li> <li>• Sexual orientation - Not reported for either patients or carers.</li> </ul>	<p>Home group: The burden for the home group stays about the same on the 2 follow-up assessments at 3 months and 1 year.</p> <p>To the question ‘Do you sometimes feel as if you would like to run away from the entire situation you find yourself in?’: At 3 weeks - acknowledged by 30% of the next-of-kin in the home group vs. 60% in the day clinic group. At 1 year - acknowledged by 50% in the home group vs. 40% in the day clinic group.</p> <p>Correlations findings:  At 3 weeks - The burden of caregivers in the home group correlated significantly, with FIM motor scale (p=0.003), Functional Independence Measure - social/cognitive scale (p=0.001), Assessment of Motor and Process Skills - process skill (p=0.010) and the European Brain Injury Questionnaire (p=0.000) completed by the next-of-kin. No such correlation in the day clinic group other than the European Brain Injury Questionnaire completed by the next-of-kin.</p> <p>At one-year follow-up: No significant correlations were found for the next-of-kin in the home group. Significant correlations in the day clinic group between the burden of caregivers and the patient’s life satisfaction</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Socioeconomic position - Not reported for either patients or carers.</li> </ul> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers - Day clinic group: 17 carers.</li> <li>• Intervention numbers - Home group: 18 carers.</li> <li>• Sample size - 36 family carers of 59 stroke patients.</li> </ul> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Rehabilitation in the home setting.</li> </ul> <p>Describe intervention - The intervention began directly after discharge from the rehabilitation ward and lasted for 3 weeks. In the home group, family or friends and helpers were involved and information was given to them and the patient about the stroke, its consequences and how to deal with them. An occupational therapist and a physiotherapist offered individually tailored</p>	<p>(p=0.000), Functional Independence Measure - social/cognitive scale (p=0.000), while no significant correlations were found for the next-of-kin in the home group. There were significant correlations between the burden of care and European Brain Injury Questionnaire by the next-of-kin for both groups (p=0.000).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>training, based on the patient's needs and desires, focusing on activities in their natural context; a top-down approach to facilitate adaptation. The content varied from personal care to shopping and trying out leisure activities. As skills and strategies were directly implemented into real life it was easy for the family members to follow the progress and be aware of the ability of the patient.</p> <ul style="list-style-type: none"> <li>• Delivered by - An occupational therapist and a physiotherapist offered individually tailored training.</li> <li>• Delivered to - Carers of stroke patients after discharge.</li> <li>• Duration, frequency, intensity, etc. - Duration of intervention 3 weeks, no information on intensity or frequency.</li> <li>• Key components and objectives of intervention - See 'Intervention details'.</li> <li>• Content/session titles – N/A.</li> </ul>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Location/place of delivery – Home.</li> </ul> <p><b>Comparison intervention:</b> Day clinic group. A multi-professional team offered training at the day clinic to which the person commuted 3 times a week. There was a possibility for the next-of-kin to participate occasionally, not always feasible due to working hours, etc. for the next-of-kin. Over all accessibility for the family was not as easy as for the home group, and fewer opportunities to ask questions and get direct answers in conjunction with the training. The focus of the intervention in the day clinic group was more a bottom-up approach that focused on the training of deficits or components of function (impairment). It became more difficult for the patient as well as for the next-of-kin to understand how things at the clinic could be transferred into real life.</p> <p><b>Outcomes measured:</b></p>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>Family or caregiver related outcomes -</p> <p>Caregiver burden was assessed with the Caregiver Burden Scale, a questionnaire with 22 questions (answered in written by the carer) concerning burden from the aspects of the caregiver's health, feeling of psychological well-being, relations, social network, physical workload and environmental aspects that might be important. The 'general strain' index of the Caregiver Burden Scale was used.</p> <p>To investigate which aspects might influence burden, the Caregiver Burden Scale was used as a measure of burden and was correlated with the following instruments: the Functional Independence Measure (divided into Motor score and Social/cognitive score), Assessment of Motor and Process Skills, European Brain Injury Questionnaire - patient and close relatives version, the questionnaire of Life satisfaction</p>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>by Fugl-Meyer, National Institute of Health Stroke Scale and Barrow Neurological Institute Screening of higher cerebral functions. The National Institute of Health Stroke Scale and BNIS measured body functions, such as physical and cognitive function. The Functional Independence Measure and Assessment of Motor and Process Skills evaluated activity limitations. The European Brain Injury Questionnaire is a questionnaire concerning perceived social, cognitive and emotional problems of the stroke victim, which was given both to the patients and to the next-of-kin. The aspect of life satisfaction was only available from the patient.</p> <p><b>Follow-up:</b> Three weeks, 3 months and 1 year post-intervention.</p> <p><b>Costs?</b> No.</p>		

**4. Fjaertoft H, Indredavik B, Magnussen J et al. (2005) Early supported discharge for stroke patients improves clinical outcome. Does it also reduce use of health services and costs? One-year follow-up of a randomized controlled trial. Cerebrovascular diseases 19: 376-83**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> To compare the use of health services and the costs of these in the extended stroke unit service group with the ordinary stroke unit service group during the first year following a stroke.</p> <p><b>Methodology:</b> Randomised controlled trial.</p> <p><b>Country:</b> Norway.</p> <p><b>Source of funding:</b> Government - Norwegian Foundation for Health and Rehabilitation.</p>	<p><b>Participants:</b> Service users and their families, partners and carers - stroke patients after discharge.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - From previous study (Indredavik 2000) - mean age - Extended stroke unit service 74 years; Ordinary stroke unit service 73.8 years.</li> <li>• Sex - From previous study (Indredavik 2000) Sex (male) extended stroke unit service: 54% Ordinary stroke unit service: 44%.</li> <li>• Ethnicity - not reported.</li> <li>• Religion/belief - not reported.</li> <li>• Disability - not reported.</li> <li>• Long term health condition - Transient ischemic attack - Extended stroke unit service: 13%, Ordinary stroke unit service: 14%. Stroke - Extended stroke unit service: 12%, Ordinary stroke unit service: 16%. Hypertension -</li> </ul>	<p><b>Statistical data - service outcomes –</b></p> <p>Mean length of inpatient stay: Acute care in stroke unit: No significant difference between the 2 groups; extended stroke unit service - mean 12.6 days (range 1-48), total 2,008 days vs. ordinary stroke unit service - mean 12.5 days (range 1-64), total 2,004 days, p=0.771.</p> <p>Inpatient rehabilitation: A significant reduction in inpatient rehabilitation in the extended stroke unit service group; extended stroke unit service - mean 11.1days (range 0–182) total 1778 days vs. ordinary stroke unit service - mean 23.4 (range 0–163) total 3,732 days, p&lt;0.001 (significant).</p> <p>Hospital readmission: No significant difference between the 2 groups; extended stroke unit service mean 5.8 days (range 0–120) total 927 days vs. ordinary stroke unit service - mean 7.3 days (range 0–62), total 1,167 days, p=0.269 (non-significant).</p> <p>Nursing home/‘assisted living’: No significant difference between the 2 groups; extended stroke unit service mean 37.2 days, (range 0–344), total 5,952 days vs. ordinary stroke unit</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> +</p> <p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>Extended stroke unit service: 33%, Ordinary stroke unit service: 35%. Myocardial infarction - Extended stroke unit service: 19%, Ordinary stroke unit service: 16%. Atrial fibrillation - Extended stroke unit service: 17%, Ordinary stroke unit service: 15%. Diabetes - Extended stroke unit service: 15%, Ordinary stroke unit service: 12%.</p> <ul style="list-style-type: none"> <li>• Sexual orientation - not reported.</li> <li>• Socioeconomic position - Living alone (from Indredavik 2000) - Extended stroke unit service: 41%, Ordinary stroke unit service: 43%.</li> </ul> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers - Ordinary stroke unit service n=160.</li> <li>• Intervention numbers - Extended stroke unit service n=160.</li> <li>• Sample size – Total N=320.</li> </ul>	<p>service mean 41.9 days (range 0–356), total 6698 days, p=0.602 (non-significant).</p> <p>Total inpatient bed days: A significant reduction in inpatient stay in the extended stroke unit service group; extended stroke unit service mean 66.7 days (range 1–364), total 10,665 days vs. ordinary stroke unit service mean 85.0 days (range 1–364), total 13,601 days, p=0.012 (significant).</p> <p>Home nursing care: No significant difference between the 2 groups, a trend towards reduced requirement for home nursing service in the extended stroke unit service group; extended stroke unit service - mean 78.5 days (range 0–1536), total 12,560 days vs. ordinary stroke unit service - mean 101.4 days (range 0–1066), total 16,233 days , p=0.085 (non-significant).</p> <p>Day clinic: Significant increase in use of day care in the extended stroke unit service group; extended stroke unit service - mean 11.4 days (range 0–63), total 1831 days vs. ordinary stroke unit service - mean 8.9 days (range 0–55), total 1,438 days, p=0.027 (significant).</p> <p>Adult day care: No significant difference between the 2 groups; extended stroke unit</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Extended stroke unit service.</li> <li>• Describe intervention - Extended stroke unit service offered a comprehensive follow-up stroke service organized by a coordinating mobile team that followed the patient for the first month after discharge from hospital. They established a programme and support system that allowed the patient to live at home as soon as possible and to continue rehabilitation at home or in a day clinic. The mobile team consisted of a physiotherapist, an occupational therapist, a nurse and the part-time service of a physician. One of the therapists acted as a case manager for the patient.</li> <li>• Delivered by - A physiotherapist, an occupational therapist, a nurse and the part-time service of a physician.</li> <li>• Delivered to - Stroke patients after discharge.</li> </ul>	<p>service - mean 3.5 days (range 0–96), total 556 days vs. ordinary stroke unit service - mean 4.0 days (range 0–99), total 645 days, p=0.720 (non-significant).</p> <p>General practitioner: No significant difference between the 2 groups; extended stroke unit service - mean 7.5 days (range 0–58), total 1199 days vs. ordinary stroke unit service - mean 6.4 days (range 0–35), total 1027 days, p=0.184 (non-significant).</p> <p>Physiotherapist: No significant difference between the 2 groups; extended stroke unit service - mean 4.5 days (range 0–58), total 721 days vs. ordinary stroke unit service - mean 4.8 days (range 0–57), total 768 days, p=0.745 (non-significant).</p> <p>Occupational and speech therapists: No significant difference between the 2 groups; extended stroke unit service - mean 1.5 days (range 0–56), total 241 days vs. ordinary stroke unit service - mean 1.2 days (range 0–34), total 117 days, p=0.260 (non-significant).</p> <p><b>Mean costs/patient during the first 52 weeks after stroke (in Euros) -</b> Acute care in stroke unit: Extended stroke unit service - mean 5,485 (range 437–20,979) vs.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Duration, frequency, intensity, etc. - not reported.</li> <li>• Key components and objectives of intervention - To assess if the extended stroke unit service reduced health service use and costs.</li> <li>• Content/session titles – N/A.</li> <li>• Location/place of delivery – Home.</li> </ul> <p><b>Comparison intervention:</b> Ordinary stroke unit service organized by the primary health care system with further inpatient rehabilitation or a follow-up programme organized after discharge from hospital.</p> <p><b>Outcomes measured:</b> Service outcomes –</p> <ul style="list-style-type: none"> <li>• Health service use and costs.</li> </ul> <p><b>Follow-up:</b> 1 year.</p> <p><b>Costs?</b> Cost information.</p>	<p>ordinary stroke unit service - mean 5474 (range 437–32,343), p=0.504 (non-significant).</p> <p>Inpatient rehabilitation: Extended stroke unit service - mean 2,053 (range 0–35,001) vs. ordinary stroke unit service - mean 4178 (range 0–31,540), p=0.000 (significant).</p> <p>Home based rehabilitation: Extended stroke unit service - mean 4065 (range 0–46,829) vs. ordinary stroke unit service - mean 4339 (range 0–36,235), p=0.532 (non-significant).</p> <p>Nursing home/‘assisted living’: Extended stroke unit service - mean 4233 (range 0–39,560) vs. ordinary stroke unit service - mean 4645 (range 0–39,548), p=0.560 (non-significant).</p> <p>Hospital readmission: Extended stroke unit service - mean 2532 (range 0–52,448) vs. ordinary stroke unit service - mean 3188 (range 0–27,098), p=0.229 (non-significant).</p> <p>Mobile team: Extended stroke unit service only: mean 569.</p> <p>All health service costs: Extended stroke unit service - mean 18,937 (range 481–92,498) vs.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		ordinary stroke unit service - mean 21,824 (range 569–92,792), p=0.127 (non-significant).	

**5. Inglis SC, Pearson S, Treen S et al. (2006) Extending the horizon in chronic heart failure: Effects of multidisciplinary, home-based intervention relative to usual care. Circulation 114: 2466-73**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> To examine the long-term (minimum of 7.5 to 10 years) impact of a nurse-led, multidisciplinary home based intervention versus usual post-discharge care in an old and fragile cohort of 297 congestive heart failure patients discharged from short-term hospital care.</p> <p><b>Methodology:</b> Randomised controlled trial.</p>	<p><b>Participants:</b> Service users and their families, partners and carers - patients with chronic congestive heart failure.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - mean age 75 years.</li> <li>• Sex - 56% males.</li> <li>• Ethnicity - 42-44% non- English speaking.</li> <li>• Religion/belief - not reported.</li> <li>• Disability - not reported.</li> <li>• Long term health condition - Previous admission for heart failure ranged from 55-63 %. Comorbidity: Past myocardial infarction- 50-55%. Chronic airways disease- 32-40%. Chronic hypertension- 57-58%. Non-insulin-dependent/insulin-dependent diabetes- 26-31%.</li> </ul>	<p><b>Statistical data - service user related outcomes –</b></p> <p>All-cause mortality: Significantly fewer participants in the home based intervention group died compared with usual care; home based intervention n=114 (77%) vs. usual care n=132 (89%), adjusted relative risk = 0.74; 95% Confidence Interval 0.53 to 0.80; p&lt;0.001.</p> <p>Median survival: Significantly higher survival rate in home based intervention group; home based intervention 40 months vs. usual care: 22 months, p&lt;0.001.</p> <p>Prolonged event-free survival: Significant increase in home based intervention group; home based intervention median of 7 event free months vs. usual care median of 4 event free months, p&lt;0.01.</p> <p>Days of hospital-free survival: More days in home based intervention group; home based intervention 1,448 (SD±1,187) vs. usual care:</p>	<p><b>Overall assessment of internal validity: +</b></p> <p><b>Overall assessment of external validity: +</b></p> <p><b>Overall validity rating: +</b></p>

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<p><b>Country:</b> Not UK. Australia.</p> <p><b>Source of funding:</b> Government - National Heart Foundation, and National Health and Medical Research Council of Australia.</p>	<p>Mean Charlson Index score- 2.8-2.9.</p> <ul style="list-style-type: none"> <li>Sexual orientation - not reported.</li> <li>Socioeconomic position - Living alone 36-41%, no other information.</li> </ul> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>Comparison numbers - Usual care n=148.</li> <li>Intervention numbers - Home-based intervention n=149.</li> <li>Sample size – Total n=297.</li> </ul> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>Intervention category - Home-based intervention as a congestive heart failure management programme. Describe intervention - Usual care and home based intervention. Home-based intervention comprised a structured home visit within 7 to 14 days of discharge, by a nurse and pharmacist, or by a qualified cardiac nurse. During the home visit, patients</li> </ul>	<p>1,010 (SD+/-999), p&lt;0.001, adjusted for being prescribed a Beta blocker at baseline, relative risk = 0.76, 95% CI 0.61 to 0.96, p=0.010.</p> <p>Number of unplanned readmissions: More in home based intervention group: home based intervention 560; usual care: 550. However, when adjustments are made for duration of follow-up and HBI-related survival time, HBI group's rate of readmission was significantly lower. It took 7 years for the 2 groups to match.</p> <p>Rate of readmission per patient per year: Significantly lower in home based intervention group. Home based intervention: 2.04 (SD +/- 3.23) vs. usual care: 3.66 (SD±7.62), p=0.039.</p> <p>Days of recurrent hospital stay per patient per year: Significantly lower in home based intervention group: home based intervention 14.8 (SD±23) vs. usual care 28.4 (SD±53.40, p&lt;0.045.</p> <p>Average length of stay for readmission: Lower in home based intervention group; home based intervention 8.2(SD±5.5) vs. usual care: 8.8 (SD±6.5), non-significant.</p> <p>Elective admissions (predominantly surgical procedures): More in home based intervention</p>	

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	<p>underwent a physical examination and a review of their adherence to and knowledge of their condition and prescribed treatments as well as an assessment of their social support system. Factors likely to increase the immediate and longer-term probability of hospital readmission or death were identified, such as undiagnosed early clinical deterioration and an impaired ability to recognize signs of an impending crisis, poor self-care behaviours and/or were taking potentially harmful medication. On the basis of this comprehensive home assessment, patients and their families received a combination of remedial counselling, introduction of strategies designed to improve treatment adherence, introduction of a simple exercise regimen, and incremental monitoring by family/caregivers. Those with signs of clinical deterioration were immediately reviewed by</p>	<p>group; home based intervention 159 vs. usual care 92, non-significant. Home based intervention was associated with 120 more life-years per 100 participants treated compared with usual care (405 vs. 285 years) at a cost of \$1729 per additional life-year gained when we accounted for healthcare costs including the home based intervention.</p> <p>Healthcare costs: During almost the entire remaining life span of this cohort, the cost-benefit of home based intervention was estimated to be AU\$1,729 per additional life-year gained.</p>	

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	<p>their primary care physician or cardiologist, and remedial action was taken. Those with problems in managing their medications were referred for long-term support by their community pharmacist. Irrespective of the outcome, a comprehensive report was sent to the patient's primary care physician and cardiologist detailing both the assessment and any actions taken or recommended. All patients had a telephone follow-up over 6 months to ensure that patients were receiving appropriate levels of support, and the patient's physicians and/or community services were contacted to address any problems. 25% of patients initiated telephone calls for advice and/or to arrange an urgent review. Both short-term (intensive) and long-term (predominantly routine and surveillance) management strategies were applied as part of the home based intervention.</p>		

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	<p>It is assumed that there was 'No restrictions were placed on the extent or the intensity of follow-up' (p2,467) which was what the usual care group received.</p> <ul style="list-style-type: none"> <li>• Delivered by - Nurse-led multidisciplinary team including community pharmacists, family physicians, community services (no details what kind of services reported).</li> <li>• Delivered to - Patients with congestive heart failure after hospital discharge.</li> <li>• Duration, frequency, intensity, etc. - See 'Describe intervention'.</li> <li>• Key components and objectives of intervention - See 'Describe intervention'.</li> <li>• Content/session titles – N/A.</li> <li>• Location/place of delivery - Patient's home.</li> </ul> <p><b>Comparison intervention:</b> Usual Patient Management (usual care) - usual levels of post-discharge planning. No restrictions were</p>		

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	<p>placed on the extent or the intensity of follow-up. This included an appointment with their primary care physician and the cardiology outpatient clinic within 14 days of discharge. All patients underwent regular outpatient-based review by a cardiologist at the hospital and attended their same primary care clinic.</p> <p><b>Outcomes measured:</b>  Service user related outcomes –</p> <ul style="list-style-type: none"> <li>• All-cause mortality.</li> <li>• Event free survival.</li> </ul> <p>Service outcomes –</p> <ul style="list-style-type: none"> <li>• Frequency of hospital admission.</li> <li>• Healthcare utilisation costs and subsequent cost per life-year saved.</li> <li>• Length of hospital stay.</li> <li>• Type of hospital admission (elective/unplanned).</li> </ul> <p><b>Follow-up:</b> Long term follow-up at ten years (minimum 7.5 years).</p>		

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	<p>Data for the same cohort of patient when followed-up at 3-6 years were assessed in another paper (Stewart 2002).</p> <p><b>Costs?</b> Cost information. Healthcare utilization costs and subsequent cost per life-year saved.</p>		

**6. Kalra L, Evans A, Perez I et al. (2005) A randomised controlled comparison of alternative strategies in stroke care. Health Technology Assessment 9: 18**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> To compare a range of outcomes at 3, 6 and 12 months between stroke patients managed on the stroke unit, on general wards with stroke team support or at home by specialist domiciliary care team.</p> <p><b>Methodology:</b> Randomised</p>	<p><b>Participants:</b> Service users and their families, partners and carers - patients with disabling stroke.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Median age – stroke unit 75 years; stroke team 77.3 years; home care 77.7 years.</li> <li>• Sex - females (%) stroke unit: 46.6, stroke team: 50.6, home care: 45.6.</li> <li>• Ethnicity - not reported.</li> <li>• Religion/belief - not reported.</li> <li>• Disability – Number of patients with premorbid independence:</li> </ul>	<p><b>Statistical data - service user related outcomes –</b></p> <p>Mortality or institutionalised at 3 months (%): Participants managed in home care were significantly more likely to die or be institutionalised compared with the stroke unit group; stroke unit 10% vs. home care 20%, relative risk = 0.50 (95% Confidence Interval 0.29 to 0.87), p=0.01. There was no significant difference in mortality or institutionalisation rate between the home care and the stroke team group; stroke team 20% vs. home care 20%, relative risk = 1.00 (95% CI 0.96 to 1.04), p=0.99.</p>	<p><b>Overall assessment of internal validity:</b> ++</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> ++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>controlled trial. Prospective, single-blind, randomised controlled trial.</p> <p><b>Country:</b> UK – South east England – Bromley.</p> <p><b>Source of funding:</b> Government - Health Technology Assessment Programme.</p>	<p>Continence: stroke unit: 146 stroke team: 147 home care: 148, Dressing: stroke unit: 146 stroke team: 143 home care: 142, Mobility: stroke unit: 145 stroke team: 146 home care: 146.</p> <ul style="list-style-type: none"> <li>• Long term health condition - Risk factor profile (%) Previous stroke/TIA: stroke unit: 26; stroke team: 29; home care: 30. Hypertension: stroke unit: 45; stroke team: 48; home care: 48. Diabetes mellitus: stroke unit: 11; stroke team: 16; home care: 15. Atrial fibrillation: stroke unit: 24; stroke team: 27; home care: 16. Smoking: stroke unit: 19; stroke team: 14; home care: 15. Ischaemic heart disease: stroke unit: 22; stroke team: 25; home care: 21. Carotid bruit: stroke unit: 3; stroke team: 5; home care: 3. Stroke characteristics: Median Orgogozo score (IQR) (extent and severity of neurological deficit): stroke unit: 75 (46–90) stroke team: 80 (60–90) home care: 85 (58–90). OPS (motor,</li> </ul>	<p>Mortality or institutionalised at 6 months (%): Participants managed in home care were more significantly likely to die or be institutionalised compared with the stroke unit group; stroke unit 13% vs. home care 24%, relative risk = 0.42 (95% CI 0.24 to 0.75), p=0.003. There was no significant difference in mortality or institutionalisation rate between the home care and the stroke team group; stroke team 25% vs. home care 24%, relative risk = 1.05, (95% CI 0.71 to 1.56), p=0.81.</p> <p>Mortality or institutionalised at 12 months (%): Participants managed in home care were significantly more likely to die or be institutionalised compared with the stroke unit group; stroke unit 14% vs. home care 23%, relative risk = 0.59 (95% CI 0.37 to 0.95), p=0.03. No significant difference in mortality or institutionalisation rate between the home care and stroke team group; stroke team 30% vs. home care 23%, relative risk = 1.28 (95% CI 0.87 to 1.87), p=0.20.</p> <p>After adjusting for age, baseline BI and dysphasia at all time-points, the odds of dying or being institutionalised at 1 year were 3.2 greater for stroke team participants and 1.8 greater for participants receiving specialist home care compared with stroke unit care.</p>	

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	<p>balance, proprioception and cognition) (1.6–6.8), median (IQR): stroke unit: 3.2 (2.4–4.4) stroke team:3.2 (2.4–4.4) home care: 2.8 (2.0–4.0) BI (Barthel Index, consisting of feeding, dressing, toilet use and mobility assessments) (0–20), median (IQR): stroke unit: 8 (5–12) stroke team: 9 (5–12) home care:10 (4–14).</p> <ul style="list-style-type: none"> <li>• Sexual orientation - not reported.</li> <li>• Socioeconomic position - lives alone (%) stroke unit: 33.7 stroke team: 36.6 home care: 33.5.</li> </ul> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers - 152 stroke unit care (n=152), stroke team care (n=152).</li> <li>• Intervention numbers - domiciliary care (n=153).</li> <li>• Sample size – Total n=457.</li> </ul> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Stroke care and management at home</li> </ul>	<p>Cox’s regression survival analysis; stroke unit vs. home care - Hazards ratio = 1.7 (95% CI 1.0 to 3.0), p=0.04 (significant).</p> <p>Mortality rates at 3 months: There was a significantly higher mortality rate in the home care group than the stroke unit group; stroke unit 4% vs. home care 10%, relative risk = 0.41 (95% CI 0.17 to 0.98, p=0.05). There was no significant difference in mortality rate between the stroke team and the home care groups; stroke team 12% vs. home care 10%, relative risk = 1.24 (95% CI 0.64 to 2.38, p=0.52).</p> <p>Mortality rates at 6 months: There was no significant difference in mortality rate between the stroke unit and the home care groups; stroke unit 7% vs. home care 13%, relative risk = 0.50 (95% 0.25 to 1.02, p=0.06). There was no significant difference in mortality rate between the stroke team and the home care groups; stroke team 17% vs. home care 13%, relative risk = 1.27 (95% CI 0.74 to 2.19, p=0.39).</p> <p>Mortality rates at 1 year: There was no significant difference in mortality rate between the stroke unit and the home care groups; stroke unit 9% vs. home care 15%, relative risk = 0.59 (95% CI 0.31 to 1.11, p=0.10). There</p>	

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	<p>after discharge.</p> <p>Describe intervention - Home (domiciliary) care (home care): Patients in the home care group were managed in their own home by a specialist team consisting of a doctor (specialist registrar), a nurse (G grade) and therapists (senior I grades), with support from district nursing and social services for nursing and personal care needs. Patients were under the joint care of the stroke physician and GP, who retained the clinical responsibility for patients managed in the community, supported by the stroke team. The stroke team consisted of the stroke nurse (coordinator), doctor, physiotherapist and occupational therapist, and will be supported by the district nurses and social services care managers. They liaised closely with the GP and the stroke consultant to maintain continuity of care, provided timely information on progress</p>	<p>was no significant difference in mortality rate between the stroke team and the home care groups; stroke team 23% vs. home care 15%, relative risk = 1.56 (95% CI 0.96 to 2.53, p=0.07).</p> <p>Barthel Index scores at 3 months: There was no significant difference between the 3 groups; stroke unit 82% vs. home care 73%, relative risk = 1.11 (95% CI 0.99 to 1.25), p=0.09 (non-significant); stroke team 70% vs. home care 73%, relative risk = 0.96 (95% CI 0.83 to 1.11), p=0.58 (non-significant).</p> <p>Dependence (modified Rankin Scale, survival without severe disability) at 1 year: Significantly less participants survived without severe disability in the home care group compared with the stroke unit group; stroke unit 85% vs. home care 71%, relative risk = 1.21 (95% CI 1.07 to 1.37, p=0.002). There were no significant differences between the stroke team and the home care groups; stroke team 66% vs. home care 71%, relative risk = 0.94 (95% CI 0.81 to 1.09, p=0.42).</p> <p>Changes in Barthel Index scores at 6 months and 1 year for survivors (stroke unit n=138; stroke team n=115; home care n=123) -</p>	

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	<p>and were responsive to general practice concerns and comments. Investigations, including CT scanning, were performed on an outpatient basis. Therapy was provided by members of the specialist stroke team. Each patient had an individualised integrated care pathway outlining activities and the objectives of treatment, which was reviewed at weekly multidisciplinary meetings. This support was provided for a maximum of 3 months. Patients' progress were monitored on a regular basis in multidisciplinary meetings. The team reviewed patients on the basis of comprehensive assessments, goals and progress. Problems in rehabilitation of individual patients were discussed at these meetings. Patient/carer involvement was encouraged as appropriate. Specialist support was provided from the hospital to support the 'shared care' with GPs.</p>	<p>baseline comparisons similar for age, gender and premorbid functional abilities: Survivors in the stroke unit showed a significantly greater change than those in the home care group at 6 months (stroke unit 9 vs. home care 7, <math>p&lt;0.02</math>) and at 1 year (stroke unit 10 vs. home care 7, <math>p&lt;0.002</math>).</p> <p>Changes in FAI scores for survivors (stroke unit <math>n=138</math>; stroke team <math>n=115</math>; home care <math>n=123</math>) - baseline comparisons similar for age, gender and premorbid functional abilities: Differences from pre-stroke and post stroke function were greatest in the stroke unit group and least in those in the home care group (<math>p&lt;0.005</math> at 6 months; <math>p&lt;0.01</math> at 1 year).</p> <p>Hospital Anxiety and Depression Scale scores – Anxiety: There were no significant differences between the 3 groups at 3 months (stroke unit 3 vs. stroke team 4 vs. home care 3), or at 1 year (stroke unit 2 vs. stroke team 2 vs. home care 2).</p> <p>Hospital Anxiety and Depression Scale scores – Depression: There were no significant differences between the 3 groups at 3 months (stroke unit 3 vs. stroke team 3 vs. home care 3), or at 1 year (stroke unit 2.5 vs. stroke team 3 vs. home care 2).</p>	

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	<ul style="list-style-type: none"> <li>• Delivered by - Stroke team (see intervention details).</li> <li>• Delivered to - Stroke patients</li> <li>• Duration, frequency, intensity, etc. - Support by stroke team at home for 3 months. No report of frequency and intensity.</li> <li>• Key components and objectives of intervention - See 'describe intervention'.</li> <li>• Content/session titles - Home care for stroke patients after discharge.</li> <li>• Location/place of delivery – home.</li> </ul> <p><b>Comparison intervention:</b> Two control interventions: Stroke Unit (stroke unit): patients in this group received care on the stroke unit (acute and rehabilitation) was provided by a stroke physician supported by a multidisciplinary team with specialist experience in stroke management. There were clear guidelines for acute care, prevention of complications, rehabilitation and secondary prevention, and a culture of joint</p>	<p>EuroQuol analogue scores: Significant higher rating in the stroke unit and the home care groups compared with the stroke team group at 3 months (stroke unit 75 vs. stroke team 60 vs. home care 73, home care vs. stroke team, <math>p &lt; 0.005</math>). There was no significant difference between the 3 groups at 1 year (stroke unit 80 vs. stroke team 75 vs. home care 75).</p> <p><b>Statistical data - satisfaction with services -</b> Patient satisfaction at 3 months: Patients in the home care group were more satisfied with the care provided by the domiciliary stroke team compared with the stroke unit or the stroke team. This was significant for 'being able to talk about problems with professionals' (Chi-sq 25.5, <math>p &lt; 0.0001</math>), 'information on the nature and cause of the stroke' (Chi-sq 8.6, <math>p &lt; 0.014</math>) 'organisation of care at home' (Chi-sq 11.6, <math>p &lt; 0.003</math>), 'support from community services' (Chi-sq 13.2, <math>p &lt; 0.001</math>), 'the amount of contact with the specialist team' (Chi-sq 99.4, <math>p = 0.009</math>).</p> <p>Carer's satisfaction: Carers rated care provided at home to be more satisfactory than that provided on the stroke unit or stroke team. This was significant for 'attention to personal needs</p>	

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	<p>assessments, goal setting, coordinated treatment and discharge planning. A coordinated multidisciplinary approach was adopted towards rehabilitation, with emphasis on early mobilisation. All patients had an individualised rehabilitation plan with clearly defined goals based on joint assessments. Patient participation was encouraged, with focus on motivation and providing an enriched environment. A plan of management, individualised to each patient's needs, was formulated and communicated to the various professionals involved in the patient's care, the patient and the family. All patients were screened and managed for stroke risk factors and secondary prevention. There was close liaison between various disciplines, with problems being addressed as they arose. Discharges were planned in advance, and spouses and relatives were encouraged to</p>	<p>of the patient' (Chi-sq = 13.1, p=0.001), 'recognition of problems associated with caring for stroke participants' (Chi-sq 22.1, p&lt;0.0001), 'amount of therapy provided (Chi-sq 13.8, p=0.001), information on benefits and services (Chi-sq 10.6, p=0.005) 'the level of contact with the specialist team' (Chi-sq 23.8, p&lt;0.0001).</p> <p>Professional acceptability of domiciliary care (GPs, district nurses and social services care managers): The sample was too small to allow meaningful statistical analysis.</p> <p><b>Statistical data - service outcomes –</b>  Length of hospital stay (mean number of days):  Stroke unit 32 (29.6 SD) vs. stroke team 29.5 (40.1 SD) vs. home care 48.9 (26.6 SD) for 51 participants requiring hospital admission from home.  Physiotherapy (% of participants treated):  Similar between the 3 groups; stroke unit 99% vs. stroke team 97% vs. home care 99%.</p> <p>Occupational therapy (% of participants treated): Similar between the 3 groups; stroke unit 100% vs. stroke team 87% vs. home care 99%.</p> <p>Speech therapy (% of participants treated):  Lower use in the home care group than the</p>	

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	<p>participate in the rehabilitation process. Stroke team (stroke team): Patients in the stroke team care were managed on general wards and remained under the care of admitting physicians. All patients were seen by a specialist team, which consisted of a doctor (specialist registrar grade), a nurse (grade G), a physiotherapist (senior I) and an occupational therapist (senior I) with expertise in stroke management. Patients were assessed and evaluated for medical, nursing and therapy needs, based on a plan for investigations and acute management guided by standardised guidelines. Although generic staff on the ward provided the day-to-day treatment, the team advised reviewed progress and treatment goals of individual patients with the ward team and helped in discharge planning and setting up of post-discharge services. The team also provided counselling, education and support to the</p>	<p>stroke unit group; stroke unit 71% vs. stroke team 47% vs. home care 49%. Patients on the stroke unit received significantly more therapy compared with those managed by the stroke team or at home. There were no significant differences in the duration of therapy between the stroke team and the home care group.</p>	

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	<p>family, identified expectations and advised about realistic outcomes in the context of previous morbidity and present deficits.</p> <p><b>Outcomes measured:</b>  Service user related outcomes -</p> <ul style="list-style-type: none"> <li>• Death or institutionalisation at 1 year.</li> <li>• Dependence (measured using modified Rankin Scale - death is rated as 6), and the Barthel Index (scores of 15–20 classified as favourable).</li> <li>• Disability (measured using Barthel Index and Frenchay Activities Index).</li> <li>• Extent and severity of neurological deficit (measured using the Orgogozo scale).</li> <li>• Mood (measured using Hospital Anxiety and Depression Scale).</li> <li>• Quality of life (measured using EuroQol).</li> </ul> <p>Family or caregiver related outcomes –</p>		

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	<ul style="list-style-type: none"> <li>• EuroQol for quality of life of patients' carers.</li> </ul> <p>Satisfaction with services –</p> <ul style="list-style-type: none"> <li>• Satisfaction with care and professional acceptability.</li> </ul> <p>Family or caregiver related outcomes –</p> <ul style="list-style-type: none"> <li>• Quality of life (EuroQol).</li> </ul> <p>Satisfaction with services –</p> <ul style="list-style-type: none"> <li>• Satisfaction with care and professional acceptability.</li> </ul> <p>Service outcomes -</p> <ul style="list-style-type: none"> <li>• Length of hospital stay.</li> </ul> <p><b>Follow-up:</b> At 3, 6 and 12 months.</p> <p><b>Costs?</b> Cost information. Please see economic evidence tables.</p> <p><b>Participants:</b> Service users and their families, partners and carers - patients with disabling stroke.</p> <p><b>Sample characteristics:</b></p>		

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	<ul style="list-style-type: none"> <li>• Age - Median age - stroke unit 75 years; stroke team support 77.3 years; home care 77.7 years.</li> <li>• Sex - females - stroke unit 46.6, stroke team support 50.6, home care 45.6%.</li> <li>• Ethnicity - not reported.</li> <li>• Religion/belief - not reported.</li> <li>• Disability – Number of patients with premorbid independence in continence (stroke unit n=146; stroke team support n=147; home care n=148), dressing (stroke unit n=146; stroke team support n=143; home care n=142), mobility (stroke unit n=145; stroke team support n=146; home care: n=146).</li> <li>• Long term health condition – Risk factor profile - Previous stroke/transient ischaemic attack - stroke unit 26%; stroke team 29%; home care 30%. Hypertension - stroke unit: 45%; stroke team 48%; home care 48%. Diabetes mellitus - stroke unit: 11%; stroke team</li> </ul>		

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	<p>16%; home care 15%. Atrial fibrillation - stroke unit 24%; stroke team 27%; home care 16%. Smoking - stroke unit: 19%; stroke team 14%; home care 15%. Ischaemic heart disease - stroke unit: 22%; stroke team 25%; home care 21%. Carotid bruit - stroke unit 3%; stroke team 5%; home care 3%. Median Orgogozo score - stroke unit 75 (46–90 IQR); stroke team 80 (60–90 IQR); home care 85 (58–90 IQR). Median OPS score (1.6–6.8) - stroke unit 3.2 (2.4–4.4 IQR); stroke team 3.2 (2.4–4.4 IQR); home care 2.8 (2.0–4.0 IQR). Median Barthel Index score - stroke unit 8 (5–12 IQR); stroke team 9 (5–12 IQR); home care 10 (4–14 IQR).</p> <ul style="list-style-type: none"> <li>• Sexual orientation - Not reported.</li> <li>• Socioeconomic position - Lives alone - stroke unit 33.7%; stroke team 36.6% home care 33.5%.</li> </ul>		

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	<p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers - domiciliary care (n=153).</li> <li>• Intervention numbers - 152 stroke unit care (n=152), stroke team care (n=152).</li> <li>• Sample size – Total N=457.</li> </ul> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Stroke care managed on the stroke unit vs. on general wards with stroke team support vs. at home by specialist domiciliary team.</li> </ul> <p>Describe intervention - Two interventions: 1. Stroke team (stroke team): Patients in the stroke team care were managed on general wards and remained under the care of admitting physicians. All patients were seen by a specialist team, which consisted of a doctor (specialist registrar grade), a nurse (grade G), a physiotherapist (senior I) and an occupational therapist (senior I) with expertise in stroke management. Patients</p>		

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	<p>were assessed and evaluated for medical, nursing and therapy needs, based on a plan for investigations and acute management guided by standardised guidelines</p> <p>Although generic staff on the ward provided the day-to-day treatment, the team advised reviewed progress and treatment goals of individual patients with the ward team and helped in discharge planning and setting up of post-discharge services. The team also provided counselling, education and support to the family, identified expectations and advised about realistic outcomes in the context of previous morbidity and present deficits.</p> <p>2. Stroke Unit (stroke unit): patients in this group received care on the stroke unit (acute and rehabilitation) was provided by a stroke physician supported by a multidisciplinary team with specialist experience in stroke management. There were clear guidelines for acute</p>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>care, prevention of complications, rehabilitation and secondary prevention, and a culture of joint assessments, goal setting, coordinated treatment and discharge planning. A coordinated multidisciplinary approach was adopted towards rehabilitation, with emphasis on early mobilisation. All patients had an individualised rehabilitation plan with clearly defined goals based on joint assessments. Patient participation was encouraged, with focus on motivation and providing an enriched environment. A plan of management, individualised to each patient's needs, was formulated and communicated to the various professionals involved in the patient's care, the patient and the family. All patients were screened and managed for stroke risk factors and secondary prevention. There was close liaison between various disciplines, with problems being addressed</p>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>as they arose. Discharges were planned in advance, and spouses and relatives were encouraged to participate in the rehabilitation process.</p> <ul style="list-style-type: none"> <li>• Delivered by - Stroke team (stroke team) in hospital: delivered by a specialist team, which consisted of a doctor (specialist registrar grade), a nurse (grade G), a physiotherapist (senior I) and an occupational therapist (senior I) with expertise in stroke management. Stroke unit (stroke unit) in hospital: (acute and rehabilitation) care provided by a stroke physician supported by a multidisciplinary team with specialist experience in stroke management.</li> <li>• Delivered to - Stroke patients.</li> <li>• Duration, frequency, intensity, etc. - No report of duration, frequency and intensity of intervention. Outcomes were assessed at 3, 6 and 12 months.</li> </ul>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Key components and objectives of intervention - See 'describe intervention'.</li> <li>• Content/session titles – N/A.</li> <li>• Location/place of delivery - Stroke team and stroke unit in hospital (bed based).</li> </ul>		

## Review question 1 – Critical appraisal tables – Effectiveness

### 1. Crotty M, Giles LC, Halbert J et al. (2008) Home versus day rehabilitation: A randomised controlled trial. Age and Ageing 37: 628-33

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To '... assess the effect of home versus day rehabilitation on patient outcomes' (p628).</p> <p><b>Description of theoretical approach?</b> No. The authors do not provide a theory of change of logic model, it is simply noted that both hospital and home based rehabilitation programmes have been shown to be effective.</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Not reported. The authors do not provide detail in relation to exposure.</p> <p><b>Was contamination acceptably low?</b> Not reported.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> Partly. Participants in the day hospital based programme received</p>	<p><b>Does the study's research question match the review question?</b> Yes. The study aims to '... assess the effect of home versus day rehabilitation on patient outcomes' (p628).</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. Informed consent was provided by participants (or their proxy if cognitive difficulties were an issue) and the study was</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>How was selection bias minimised?</b> Randomised computer generated block randomisation, stratified by presenting condition.</p> <p><b>Was the allocation method concealed?</b> Yes.</p> <p><b>Were participants blinded?</b> Blinding not possible. Due to the nature of the intervention it would not have been possible to blind participants.</p> <p><b>Were providers blinded?</b> Blinding not possible. Due to the nature of the intervention it would not have been possible to blind providers.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Part blind. Discharge assessments were conducted by the clinical team who were not blinded to group assignment, however follow-up assessments and</p>	<p>more services with participants randomised to this group receiving an average of 67.8 sessions (SD=8.6) compared to an average of 23.5 sessions (SD=14.7) in the home based rehabilitation programme (significance not reported). Participants randomised to the day hospital based group also spent longer in the programme than those in the home based programme (median of 78 days, 95% Confidence Interval 71.6 to 83 vs. 28 days, 95% CI 26 to 30 days) which the authors report as significant (p&lt;0.001). Participants in both groups also appear to have spent time in rehabilitation prior to randomisation although it is not clear whether this differed significantly by group.</p> <p><b>Were outcomes relevant?</b> Yes. The study aimed to evaluate the effects of the intervention and control on outcomes such as functional competence in activities of daily living and</p>	<p>approved by a number of ethics committees.</p> <p><b>Were service users involved in the design of the study?</b> No. No indication that service users were involved in the design of the study or interpretation of findings.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study focuses on hospital based day rehabilitation and home based rehabilitation both of which are described as multidisciplinary programmes generally lasting for 4 to 6 weeks.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. The participants of the study are individuals referred for ambulatory rehabilitation at the end of a hospital stay. The mean age of the group was 71.7 years however there were 5 participants who were younger than 30 and 4 who were older than 90.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>statistical analysis were both conducted by researchers blinded to group assignment.</p> <p><b>Did participants represent the target group?</b> Yes. An acceptable number of eligible individuals agreed to participate (229 were randomised out of 267 who were eligible). The mean age of participants was 71.7 years although a number of participants below the age of 30 and over the age of 90 were included in the sample. One individual was excluded on the basis that they had insufficient memory.</p> <p><b>Were all participants accounted for at study conclusion?</b> Yes. The number of participants lost to follow-up was acceptable (less than 20%) and explanations are reported by the authors. Rates are comparable by group.</p>	<p>quality of life, as well as carer strain and carer quality of life and these were measured directly.</p> <p><b>Were outcome measures reliable?</b> Yes. All measures have established reliability and validity however data in relation to this are not presented. Both observational and self-report measures are used although the primary outcome is measure is observational.</p> <p><b>Were all outcome measurements complete?</b> Yes. All outcome data was measured and reported as planned.</p> <p><b>Were all important outcomes assessed?</b> Partly. Although the outcomes assessed are comprehensive, between group differences for mortality and admission to residential care are not analysed/reported.</p>	<p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. The interventions were delivered in a day hospital and participants homes. Follow-up assessments took place in participant's homes.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. Both the intervention and control are short-term, multidisciplinary rehabilitation programmes.</p> <p><b>(For effectiveness questions) Are the study outcomes relevant to the guideline?</b> Yes. The primary outcome was change in functional competence in activities of daily living. Other outcomes included depression, quality of life, hospital readmissions, carer quality of life and carer stress.</p> <p><b>(For views questions) Are the views and experiences reported relevant to the</b></p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. Both groups were followed up for an equal length of time.</p> <p><b>Was follow-up time meaningful?</b> No. The total follow-up period was 6 months which is only long enough to detect short-term effects and the majority of measures were only assessed at 3 months.</p> <p><b>Were the analytical methods appropriate?</b> Yes.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Yes. The authors report that the 2 groups were similar at baseline with respect to demographic characteristics and functional ability and quality of life related outcome measures however significance testing is not reported.</p>	<p><b>guideline?</b> Not applicable (not views question). No views and experiences data provided.</p> <p><b>Was the study conducted in the UK?</b> No. The study was conducted in Australia.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Was intention to treat (ITT) analysis conducted?</b> Yes.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Yes. The authors provide a power calculation based on data in relation to the primary outcome measure (Assessment of Motor and Process Skills). This showed that to detect a clinically significant change of 0.5 on this measure (0.8 power, significance level of 0.05), 60 participants were required in each group. 229 participants were randomised in total. The authors report that they increased the sample size to allow for stratified randomisation and 25% attrition.</p> <p><b>Were the estimates of effect size given or calculable?</b> No. Effect sizes are not provided.</p> <p><b>Was the precision of intervention effects given or</b></p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>calculable? Were they meaningful?</b> Partly. p values and confidence intervals are reported for some outcomes but this is not consistent.</p> <p><b>Do conclusions match findings?</b> Partly. The authors conclude that home is a better site for rehabilitation. This appears to be on the basis of risk of readmission and time to first readmission however it should be noted that day hospital had significantly better Functional Independence Measure scores at 3 months and significantly greater change scores on this measure. The authors suggest that this difference was due to unblinded assessments. The authors also state that both groups made significant improvements in functional outcomes but this only appears to be the case for scores on the Functional Independence Measure.</p>		

**2. Jackson JC, Ely EW, Morey MC et al. (2012) Cognitive and physical rehabilitation of intensive care unit survivors: Results of the RETURN randomized controlled pilot investigation. Critical Care Medicine 40(4): 1088-97**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To test the following hypothesis - in a cohort of ICU survivors, a 'bundled' rehabilitation approach combining cognitive, physical, and functional rehabilitation could be developed and effectively delivered in the home using novel tele-video technology delivered via social workers and would result in greater improvement in cognition and functional outcomes in intervention than control participants.</p> <p><b>Description of theoretical approach?</b> Yes. A critical evaluation of existing research led the researchers to hypothesize that a rehabilitation approach combining cognitive, physical, and functional training could have enhanced effects related to the beneficial physiological</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Partly. Eligibility criteria were changed during the trial to allow for the inclusion of participants who were discharged to a nursing home or rehabilitation centre.</p> <p><b>Was contamination acceptably low?</b> Yes.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> Partly. The authors do not know details about the control groups' involvement in outpatient rehabilitation because they were unable to gather that information from half of all participants. Furthermore, usual care may have included physical therapy, occupational therapy and nursing care delivered to</p>	<p><b>Does the study's research question match the review question?</b> Yes.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. Researchers at Vanderbilt University, Duke University, and the Nashville (Tennessee Valley) and Durham VA Medical Centers supervised the trial and institutional review boards (IRBs) approved the protocol. Having said that, there is no discussion of ethical issues associated with withholding the intervention from the control participants.</p> <p><b>Were service users involved in the design of the study?</b> No.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes.</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>effects of exercise on cognition (and potentially on the responsiveness to cognitive training) as well as the effects of functional training facilitating translation of newly acquired skills into daily life.</p> <p><b>How was selection bias minimised?</b> Randomised. Randomisation was done using a 2:1 randomization scheme (intervention vs. control) to maximize knowledge gained from the number of participants in the study's intervention group. Permuted block randomization was employed, with block sizes of 3 and 6.</p> <p><b>Was the allocation method concealed?</b> Yes. Randomization was concealed via tri-folded randomization sheets placed in sealed opaque envelopes. Staff enrolling study participants were thus blinded as to which</p>	<p>in-patient, out-patient or home health settings.</p> <p><b>Were outcomes relevant?</b> Yes.</p> <p><b>Were outcome measures reliable?</b> Yes.</p> <p><b>Were all outcome measurements complete?</b> No. Although it is not terribly clear, it appears that up to 6 intervention participants dropped out between baseline and follow up. We're assured that the characteristics of these people were similar to those of the people who completed the study.</p> <p><b>Were all important outcomes assessed?</b> Yes.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. 3 months.</p>	<p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Partly. Yes although it should be noted that the study was conducted in the US where the different health care system may have a bearing on external validity and applicability.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes.</p> <p><b>(For effectiveness questions) Are the study outcomes relevant to the guideline?</b> Yes.</p> <p><b>Was the study conducted in the UK?</b> No.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>group the next eligible patient would be randomised.</p> <p><b>Were participants blinded?</b> Not reported.</p> <p><b>Were providers blinded?</b> Not blind.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Not blind.</p> <p><b>Did participants represent the target group?</b> Partly. The study applied extensive exclusion criteria including: accidents or diseases with resulting moderate to severe cognitive deficits or ADL dependency - active substance abuse or psychotic disorder - prisoners - patients living beyond a 125 mile radius - the presence of normal cognition <i>and</i> normal physical function at the time of discharge - lack of telephone service with analogue telephone line - discharge</p>	<p><b>Was follow-up time meaningful?</b> Partly. An additional, longer term follow up would have improved the study e.g. 6 or 12 months.</p> <p><b>Were the analytical methods appropriate?</b> Yes. Descriptive analyses regarding socioeconomic characteristics, baseline health conditions, and severity of illness were done comparing intervention and control groups using Mann-Whitney U-tests for continuous variables and Pearson chi-square tests for categorical variables. Linear regression was employed to examine differences in follow-up assessment cores on primary and secondary outcome measures between treatment groups while adjusting for baseline treatment scores. Adjusted treatment effects are the point estimates and 95% confidence intervals for the treatment coefficient in the ANCOVA models. They</p>		

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>planned to rehab centre (although this was changed mid study to allow them to join).</p> <p><b>Were all participants accounted for at study conclusion?</b> Yes. Three out of the 21 randomized patients dropped out - all from the intervention arm. Reasons: the study was inconvenient, personal reason unrelated to the study and multiple hospital readmissions.</p>	<p>describe the difference in the three-month measurement for the intervention group as compared to the control group, while adjusting for baseline measurement. Logistic regression was also employed to analyse data from our dichotomous Katz ADL outcome.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Partly  With respect to key baseline demographic and clinical characteristics, participants were generally similar, though certain differences were observed. Severity of illness, as measured via the Acute Physiology and Chronic Health Evaluation Score – II (APACHE II) and Sequential Organ Failure (SOFA) scores were slightly higher (though not statistically significantly so) in control versus intervention patients, and control patients</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>suffered from a larger number of medical comorbidities (as measured by overall scores on the Duke Comorbidity Index). Control patients also experienced longer ICU hospitalizations and greater duration of mechanical ventilation, which though not statistically significantly different may have been clinically significant. Scores on relevant outcome measures at a baseline (pre-intervention) assessment were not statistically significantly different between groups.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> No. Results are presented only for the participants who completed the study - they exclude those who dropped out.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> No. The authors say</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>that due to the preliminary nature of this investigation and its primary goals, which included hypothesis generation, evaluation of feasibility, and assessing proof of principle, a formal power analysis and was not used to determine the study's sample size, and most of the reported outcomes are underpowered.</p> <p><b>Were the estimates of effect size given or calculable?</b> No.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Partly. p values are reported and adjusted treatment effects are also given.</p> <p><b>Do conclusions match findings?</b> Yes.</p>		

**3. Mahomed NN, Davis AM, Hawker G et al. (2008) Inpatient compared with home-based rehabilitation following primary unilateral total hip or knee replacement: A randomized controlled trial. American Journal of Bone and Joint Surgery 90A(8): 1673-80**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> The aim of the study was to evaluate the effectiveness and cost of home based rehabilitation, compared with inpatient rehabilitation following primary total hip or knee joint replacement.</p> <p><b>Description of theoretical approach?</b> No. There is no description of the theory behind the evaluated intervention.</p> <p><b>How was selection bias minimised?</b> Randomised. Participants were randomised to either home based or inpatient rehabilitation.</p> <p><b>Was the allocation method concealed?</b> Not reported.</p> <p><b>Were participants blinded?</b> Not blind. Participants were</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Yes. Both interventions went as planned. There were no problems with uptake or changes made during the course of the study.</p> <p><b>Was contamination acceptably low?</b> No. Twenty participants requested a crossover from their assigned treatment group of home rehabilitation to inpatient rehabilitation.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> No. Neither of the groups received additional interventions.</p> <p><b>Were outcomes relevant?</b> Yes. Reported outcomes</p>	<p><b>Does the study's research question match the review question?</b> Yes. The study's research question is in line with the review question.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. The study was approved by the Human Subject Review Committee.</p> <p><b>Were service users involved in the design of the study?</b> No. Service users were involved as participants and not in the design of the study or interpretation of results.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study clearly relates to the overall topic of the guideline.</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>informed of their treatment allocation to either home based or inpatient rehabilitation. This was to allow sufficient time to prepare their home settings (if allocated to home based rehabilitation).</p> <p><b>Were providers blinded?</b> Not reported.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Not reported.</p> <p><b>Did participants represent the target group?</b> Yes. Participants clearly represent the target group for this intervention.</p> <p><b>Were all participants accounted for at study conclusion?</b> Yes. None of the participants were lost to follow-up.</p>	<p>clearly relate to the measures used.</p> <p><b>Were outcome measures reliable?</b> Yes. Validated questionnaires were used, and these were both subjective and objective, however data in relation to this are not provided.</p> <p><b>Were all outcome measurements complete?</b> Yes. All planned data was gathered.</p> <p><b>Were all important outcomes assessed?</b> Yes.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. Both groups were followed up 3 and 12 months after the intervention.</p> <p><b>Was follow-up time meaningful?</b> Yes. Follow-up was sufficient to assess long-term benefits or harms and no</p>	<p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. Adults using intermediate care services formed the study population.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. An acute hospital and participants' homes formed the study settings.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. The effectiveness and cost effectiveness of bed-based vs. home based intermediate care is covered in the study.</p> <p><b>(For effectiveness questions) Are the study outcomes relevant to the guideline?</b> Yes. The main outcome was the efficacy of inpatient, compared with</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>participants were lost during this time.</p> <p><b>Were the analytical methods appropriate?</b> Yes. Analysis of variance was used to evaluate differences between groups in the 2 treatment arms and differences between groups in satisfaction scores were evaluated with use of Wilcoxon rank-sum tests.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Yes. There were no significant differences between groups in important confounders at baseline.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Yes. Primary analysis was on an intention-to-treat basis. This was to ensure that any potential variables could be adjusted for in the final analysis.</p>	<p>home based, rehabilitation 3 months after surgery. Secondary outcomes included measurement of health status and patient satisfaction.</p> <p><b>Was the study conducted in the UK?</b> No. US study.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Yes. A power calculation is presented.</p> <p><b>Were the estimates of effect size given or calculable?</b> Yes. Effect size is presented (0.5).</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Not reported.</p>		

**4. Parker SG, Oliver P, Pennington M et al. (2009) Rehabilitation of older patients: Day hospital compared with rehabilitation at home. A randomised controlled trial. Health Technology Assessment 13(39): DOI 10.3310/hta13390**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> The study aimed to test the hypothesis that ‘... older people and their informal carers are not disadvantaged by home-based rehabilitation relative to day hospital rehabilitation’ (piii).</p> <p><b>Description of theoretical approach?</b> No. The authors</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Not reported. The authors do not provide any details on delivery of either the intervention or comparison.</p> <p><b>Was contamination acceptably low?</b> Not</p>	<p><b>Does the study’s research question match the review question?</b> Yes. The study aimed to test the hypothesis that ‘... older people and their informal carers are not disadvantaged by home-based rehabilitation relative to day hospital rehabilitation’ (piii).</p>	<p><b>Overall assessment of internal validity:</b></p> <p>+</p> <p>The failure to carry out 12 month follow-up assessments for some participants, high rate of attrition and lack of sufficient power mean that it</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>do not provide a clear description of their theoretical approach or a logic model. The hypothesis of the study is that home based multidisciplinary rehabilitation is not inferior to day hospital based multidisciplinary rehabilitation but there is no exploration of why this might be the case. The authors simply note that home based rehabilitation was a policy priority. It should also be noted that this intervention was not designed specifically for this trial, instead, it appears that participants were randomised at 1 of 4 centres where home based multidisciplinary rehabilitation services were already in existence.</p> <p><b>How was selection bias minimised?</b> Randomised. Permuted block randomisation using a web-based randomisation service. Randomisation was stratified by ‘... centre, AMT score and</p>	<p>reported. Information on contamination is not provided.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> Not reported. There is no indication that either group received additional interventions.</p> <p><b>Were outcomes relevant?</b> Yes. Although the outcome measures seem appropriate the discussion in relation to the types of outcomes which the service may impact and the measures which would be relevant to these is minimal. The hypothesis of the study was that older people and their carers would not be ‘disadvantaged’ by the intervention which does not really provide much focus.</p> <p><b>Were outcome measures reliable?</b> Yes. All outcome measures appear to have</p>	<p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. The protocol was approved by a research ethics committee and informed consent was provided by participants (with assistance from an advocate or carer if necessary).</p> <p><b>Were service users involved in the design of the study?</b> Yes. Patient advisory groups took part in discussions regarding the protocol.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study evaluates short-term multidisciplinary home based rehabilitation.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. All participants were over the age of 18, however the majority were aged 65 or older.</p>	<p>is not possible to award a higher score.</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>gender and by the presence of a carer' (p558).</p> <p><b>Was the allocation method concealed?</b> Not reported. Methods of allocation and concealment are not reported.</p> <p><b>Were participants blinded?</b> Blinding not possible. Due to the nature of the intervention it would not have been possible to blind participants to group assignment.</p> <p><b>Were providers blinded?</b> Blinding not possible. Due to the nature of the intervention it would not have been possible to blind participants to group assignment.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Part blind. The authors report that it was not possible to ensure that outcome assessors remained blinded; however they note that the research team were</p>	<p>established reliability and validity however data in relation to this are not provided.</p> <p><b>Were all outcome measurements complete?</b> No. Due to problems with recruitment, 12 month follow-up assessments did not take place for all participants. The number for whom this was the case is not clearly reported.</p> <p><b>Were all important outcomes assessed?</b> Partly. Although the range of service user related outcomes seem comprehensive the study did not measure mortality and it is disappointing that the only carer related outcome was psychiatric morbidity. Given that the authors emphasise the importance of service user preference in their supporting materials it is also disappointing that the study did not include a qualitative component.</p>	<p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. The interventions were delivered in the participants own homes and day hospitals. All outcome assessments were conducted in the homes of participants.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. The experimental condition was a home based multidisciplinary rehabilitation service which is relevant to home based intermediate care.</p> <p><b>(For effectiveness questions) Are the study outcomes relevant to the guideline?</b> Yes. The primary outcome was activities of daily living. Secondary outcomes included anxiety and depression, and health of carers.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>blinded until the first analyses had been conducted and discussed by the team.</p> <p><b>Did participants represent the target group?</b> No. Only 89 eligible participants were randomised out of a total of 435. Two hundred and thirty five individuals declined to participate and 111 did not take part for 'other' reasons. Only minimal data in relation to demographics of the sample are provided, for example in relation to ethnicity or socioeconomic status, however the majority of participants were over the age of 65. There is a lack of clarity in relation to inclusion and exclusion criteria. The authors note that these were set at the local level on the basis that participants with a clinical need which could only be met by a service currently provided in only 1 setting were excluded. However, they also report that potentially eligible</p>	<p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes.</p> <p><b>Was follow-up time meaningful?</b> Partly. Final follow-up assessments were conducted at 12 months (although recruitment problems meant that these were not always carried out) which may not have been sufficient to detect longer-term effects.</p> <p><b>Were the analytical methods appropriate?</b> Yes. Analysis of covariance (adjusting for baseline scores), logistic regression, Mann-Whitney U test, and binary logistic regression. The authors also report that a post hoc analysis of non-inferiority in relation to clinically significant differences was conducted which they note is problematic without predefined non-inferiority limits.</p>	<p><b>(For views questions) Are the views and experiences reported relevant to the guideline?</b> Not applicable (not views question). This study did not include any views and experiences data.</p> <p><b>Was the study conducted in the UK?</b> Yes. The study was conducted across 4 sites in England.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>people were excluded because they had not been referred for multidisciplinary rehabilitation and because of ‘... site specific service configuration ...’ (p558). It should also be noted that recruitment to the trial was ceased at an earlier point than intended due to the high numbers of people who declined to participate, the volume assessed as ineligible and changes in service configuration.</p> <p><b>Were all participants accounted for at study conclusion?</b> No. At 3 months follow-up only 72 out of 89 participants provided outcome data, by the 6 months follow-up this had fallen to 65 and by the final 12 month assessment, data was only available for 43 participants out of a total of 89 randomised. Explanations for loss to follow-up are included.</p>	<p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Yes. The authors report that the 2 groups were similar at baseline in relation to demographic characteristics however they do not report any significance testing. Analysis of continuous data used baseline scores as the covariate.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Partly. Intention to treat analysis was only conducted for 5 of the outcomes assessed at the 6 months follow-up.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> No. The authors calculated that to detect a 2 point difference on the Nottingham Extended Activities of Daily Living Scale</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>It appears that there were also 23 carers in each group although it is not clear if any of these were lost to follow-up.</p>	<p>at a significance level of 5% a sample size of 460 was required. Only 89 participants were randomised.</p> <p><b>Were the estimates of effect size given or calculable?</b> Partly. Odds ratios are provided for some outcome measures but this is not consistent.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Yes. 95% confidence intervals and <i>p</i> values are provided as appropriate.</p> <p><b>Do conclusions match findings?</b> Yes.</p>		

**5. Thorsen AM, Widen Holmqvist L, Von Koch L (2006) Early Supported Discharge and continued rehabilitation at home after stroke: 5-year follow-up of resource use. Journal of Stroke and Cerebrovascular Diseases 15(4): 139-43**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> The aim of the study was to assess the effect of Early Supported Discharge</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Not reported.</p>	<p><b>Does the study's research question match the review question?</b> Yes. The study's</p>	<p><b>Overall assessment of internal validity:</b> -</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>on use of health care and social service resources 5 years after stroke. NB. This is 1 of 2 follow-up studies, the first of which explores changes in perceived health status over the 5 years after stroke onset (Ytterberg et al. 2010), thus providing an overall picture.</p> <p><b>Description of theoretical approach?</b> No. A theoretical approach is not described.</p> <p><b>How was selection bias minimised?</b> Randomised. Participants were randomised to either Early Supported Discharge or conventional rehabilitation.</p> <p><b>Was the allocation method concealed?</b> Not reported. Details on the randomisation procedure are presented in the original RCT (von Koch et al. 2000).</p>	<p><b>Was contamination acceptably low?</b> Not reported.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> Not reported.</p> <p><b>Were outcomes relevant?</b> Yes. Reported outcomes clearly relate to the measures used.</p> <p><b>Were outcome measures reliable?</b> Yes. The authors used a variety of measures to gather data, including: - a computerised register of Stockholm County Council - telephone conversations and consultation visits - interviews with participants and/or their spouses.</p> <p><b>Were all outcome measurements complete?</b></p>	<p>research question is clearly in line with the review question.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. The study was approved by the University Hospital ethics committee.</p> <p><b>Were service users involved in the design of the study?</b> No. Service users were involved as participants, but not in the design of the study or interpretation of results.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study relates to home based intermediate care.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. The study population consisted of adults (mean age 72 years) using intermediate care (Early Supported Discharge with</p>	<p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Were participants blinded?</b> Not reported.</p> <p><b>Were providers blinded?</b> Not reported.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Blind. The assessor was blind to group assignment and had not been involved in the randomisation procedure.</p> <p><b>Did participants represent the target group?</b> Yes. Participants met selected inclusion criteria that were representative of the target group (people with stroke).</p> <p><b>Were all participants accounted for at study conclusion?</b> No. Over 20% participants were lost to follow-up (n=29). Of these, 20 had died and 9 were 'lost to follow-up' (p140).</p>	<p>Yes. All planned data was gathered.</p> <p><b>Were all important outcomes assessed?</b> Yes. Meaningful effects, in favour of Early Supported Discharge on resource use, are reported.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. Participants in both the intervention and comparison groups were followed-up 5 years after stroke.</p> <p><b>Was follow-up time meaningful?</b> Partly. 29 participants were lost during 5 year follow-up. This was potentially too long to assess this particular group.</p> <p><b>Were the analytical methods appropriate?</b> Partly. The authors gathered various types of data, including interview data, but do not go into any detail about how these were</p>	<p>continued rehabilitation at home).</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. The intervention took place in participants' homes.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. The study looks at the effect of Early Supported Discharge services on use of health care and social service resources.</p> <p><b>(For effectiveness questions) Are the study outcomes relevant to the guideline?</b> Yes. The main outcome measured was the effect of Early Supported Discharge services on use of health care and social service resources.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>analysed. For example, they only used Chi-squared and t tests, but do not say whether interview responses were coded to be reported quantitatively.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Not reported.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Not reported.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Not reported.</p> <p><b>Were the estimates of effect size given or calculable?</b> Not reported.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Yes. Confidence</p>	<p><b>Was the study conducted in the UK?</b> No. Swedish study.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>intervals and p values are reported.</p> <p><b>Do conclusions match findings?</b> Yes. Conclusions are in line with findings; that Early Supported Discharge is favourable with regards to resource use.</p>		

**6. Ytterberg C, Thorsen AM, Liljedahl M et al. (2010) Changes in perceived health between one and five years after stroke: A randomized controlled trial of early supported discharge with continued rehabilitation at home versus conventional rehabilitation. Journal of the Neurological Sciences 294: 86-8**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To explore perceived health status in people with stroke who received Early Supported Discharge, with those who received conventional rehabilitation, over 5 years after stroke onset.</p> <p>NB. This is 1 of 2 follow-up studies, the second of which explores the effect of Early Supported Discharge services on use of health care and</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Not reported.</p> <p><b>Was contamination acceptably low?</b> Not reported.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> Not reported.</p>	<p><b>Does the study's research question match the review question?</b> Yes. The study's research question is in line with the review question.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. Informed consent was obtained prior to participation in this follow-up study.</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p>Conclusions are in line with study findings, which suggest that the long term outcome with regard to perceived health status is more favourable after Early Supported Discharge than after conventional rehabilitation.</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>social service resources 5 years after stroke onset (Thorsen et al. 2006), thus providing an overall picture.</p> <p><b>Description of theoretical approach?</b> Yes. The authors present a clear and comprehensive theory that is based on existing research for why Early Supported Discharge is expected to make a difference to participants in the intervention arm.</p> <p><b>How was selection bias minimised?</b> Randomised. Participants were randomised to a home rehabilitation group or a conventional rehabilitation group. This was done in the original study.</p> <p><b>Was the allocation method concealed?</b> Not reported.</p> <p><b>Were participants blinded?</b> Not reported.</p>	<p><b>Were outcomes relevant?</b> Yes. Data on perceived health was collected using the Sickness Impact Profile (SIP), which measured perceived health-related limitations in 12 categories of activity.</p> <p><b>Were outcome measures reliable?</b> Partly. The Sickness Impact Profile has been proved to be reliable and valid for the Swedish population, however, may not be representative of the wider population. The authors also note that use of a disease-specific instrument would have offered a more detailed understanding of the perceived health status among patients after stroke.</p> <p><b>Were all outcome measurements complete?</b> Yes. All intended outcomes were measured and reported.</p> <p><b>Were all important outcomes assessed?</b> Yes. The authors</p>	<p><b>Were service users involved in the design of the study?</b> No. Service users were not involved in the design or methodology of the study.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. There is a clear focus on intermediate care.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. The study population includes adults with experience of home based intermediate care services.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. The study setting is Early Supported Discharge with continued rehabilitation in service users' homes.</p>	<p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Were providers blinded?</b> Not reported.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Not reported.</p> <p><b>Did participants represent the target group?</b> Yes. All eligible participants (n=83) were included and randomised to either the intervention or comparison condition.</p> <p><b>Were all participants accounted for at study conclusion?</b> No. Approximately 40% of participants (n=33) were lost to follow-up. Reasons for this were: death, non-residents or declined.</p>	<p>report the meaningful effects of the intervention on patients with stroke versus conventional rehabilitation. No explicit harms were reported.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. Both groups were followed-up at 3 months, 6 months, 1 and 5 years.</p> <p><b>Was follow-up time meaningful?</b> Partly. Approximately 40% of participants were lost to lengthy follow-up (five years).</p> <p><b>Were the analytical methods appropriate?</b> Yes. The Mann Whitney U-test was used for statistical analysis of differences between groups at 1 and 5 years, and the Wilcoxon sign test for differences within groups between 1 and 5 years.</p>	<p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. The intervention was home based intermediate care.</p> <p><b>(For effectiveness questions) Are the study outcomes relevant to the guideline?</b> Yes. The study outcomes are user-related (perceived health following Early Supported Discharge).</p> <p><b>Was the study conducted in the UK?</b> No. Swedish study.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Partly. The groups were comparable at baseline with regard to sociodemographic characteristics, stroke-associated conditions before onset and functioning, with the exception of more people in the home rehabilitation group with a medical history of diabetes and transient ischemic attack. There were, however, more women in the home rehabilitation group (n=13) than the conventional rehabilitation group (n=8).</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Not reported.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Not reported.</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Were the estimates of effect size given or calculable?</b> Not reported.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Yes. p values are provided.</p> <p><b>Do conclusions match findings?</b> Yes.</p>		

## Review question 1 – Critical appraisal tables – the views and experiences of people using services, their families and carers

### 1. Ariss S (2014) National audit for intermediate care: Patient reported experiences, 2014. Sheffield: University of Sheffield

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Objectives of the study clearly stated?</b> Partly. The objective is simply to answer the 1 survey question.</p> <p><b>Research design clearly specified and appropriate?</b> Partly. It is not clear exactly how the survey was conducted</p>	<p><b>Basic data adequately described?</b> Partly. More data on the numbers/ proportions making certain responses could have been provided.</p> <p><b>Results presented clearly, objectively and in enough detail for readers to make</b></p>	<p><b>Does the study's research question match the review question?</b> Yes. The survey, which was part of the NAIC 2014, asked the question 'Do you feel that there is something that could have made your experience of the service better?' Yes or No, and then a space to provide</p>	<p><b>Overall assessment of internal validity:</b> -</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> -</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>but details of the methods of analysis are provided.</p> <p><b>Clear description of context?</b> Partly. The context of the survey is clear but we do not have details about the context of the survey respondents (except that they have used home based intermediate care).</p> <p><b>References made to original work if existing tool used?</b> N/A.</p> <p><b>Reliability and validity of new tool reported?</b> Unclear. No information about the validity and reliability of the single survey question, why it was chosen or worded the way it was.</p> <p><b>Survey population and sample frame clearly described?</b> No. We only know that the sampling frame is people using home based intermediate care in England.</p>	<p><b>personal judgements?</b> Partly.</p> <p><b>Results internally consistent?</b> Partly. On the whole, yes although numbers weren't routinely provided against responses.</p> <p><b>Data suitable for analysis?</b> Yes.</p> <p><b>Clear description of data collection methods and analysis?</b> Partly. Clear description of data analysis but not data collection.</p> <p><b>Methods appropriate for the data?</b> Yes.</p> <p><b>Statistics correctly performed and interpreted?</b> Partly. In terms of statistics, only frequencies were produced and even then, not for all the themes, which means we don't know how many respondents cited each issue - this could have been</p>	<p>further information. The question was asked to people using bed based and home based intermediate care and reablement.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> No. There is no discussion of handling ethical issues or obtaining ethical approval for the survey.</p> <p><b>Were service users involved in the study?</b> No.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Representativeness of sample is described?</b> No. We have no idea how representative the sample is.</p> <p><b>Subject of study represents full spectrum of population of interest?</b> Unclear. The author does not provide any information that would help us judge whether the study represents the full spectrum of the population of interest.</p> <p><b>Study large enough to achieve its objectives, sample size estimates performed?</b> No. There's no evidence that sample size estimates have been made.</p> <p><b>All subjects accounted for?</b> No. The paper does not provide a figure for the total number of people who received the survey.</p> <p><b>Measures for contacting non-responders?</b> There's no</p>	<p>provided in the ranked table. Further statistical analyses could have been usefully produced, e.g. cross tabulations or, if the data had been collected, responses could have been linked with service users' characteristics.</p> <p><b>Response rate calculation provided?</b> No. Because we do not know how many people received the survey question.</p> <p><b>Methods for handling missing data described?</b> No.</p> <p><b>Difference between non-respondents and respondents described?</b> No.</p> <p><b>Results discussed in relation to existing knowledge on subject and study objectives?</b> No.</p> <p><b>Limitations of the study stated?</b> No.</p>	<p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes.</p> <p><b>(For views questions) Are the views and experiences reported relevant to the guideline?</b> Yes.</p> <p><b>Does the study have a UK perspective?</b> Yes. The National Audit of Intermediate Care (NAIC), now in its third year, provides a unique, 'bird's eye' view of intermediate care commissioning and provision in England.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>evidence that non responders were followed up.</p> <p><b>All appropriate outcomes considered?</b> N/A. No outcomes were measured, the survey simply comprised of 1 open ended question.</p>	<p><b>Results can be generalised?</b> Partly. Within England, probably although it's hard to tell because the author does not provide any information about the respondents.</p> <p><b>Appropriate attempts made to establish 'reliability' and 'validity' of analysis?</b> No.</p> <p><b>Conclusions justified?</b> Unclear. No conclusions are provided in this paper.</p>		

**2. Cobley CS, Fisher RJ, Chouliara N et al. (2013) A qualitative study exploring patients' and carers' experiences of Early Supported Discharge services after stroke. Clinical Rehabilitation 27(8): 750-7**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Is a qualitative approach appropriate?</b> Appropriate.</p> <p><b>Is the study clear in what it seeks to do?</b> Clear.</p> <p><b>How defensible/rigorous is the research design/methodology?</b> Defensible. Sampling, data</p>	<p><b>Is the context clearly described?</b> Unclear. We only know participants' ages and the fact they have a stroke diagnosis.</p> <p><b>Was the sampling carried out in an appropriate way?</b> Somewhat appropriate. It was self-selecting. Patients and their carers were given an</p>	<p><b>Does the study's research question match the review question?</b> Yes. A study of patient and carer views of Early Supported Discharge for stroke.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. Researchers stressed that</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p>With the caveat about Early Supported Discharge being outside the NAIC definition.</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>collection and analysis were clearly described and rational.</p> <p><b>How well was the data collection carried out?</b> Somewhat appropriately. Although it is not clear whether people were interviewed with their carers present or whether they were interviewed separately.</p>	<p>information sheet and those who wished to participate were invited to contact the researcher directly.</p> <p><b>Were the methods reliable?</b> Somewhat reliable. Data collection is only via interviews. No observation or opportunity for triangulation. 'Effectiveness' of Early Supported Discharge is based on qualitative comparisons of Early Supported Discharge vs non Early Supported Discharge so no basis for assumptions about effectiveness.</p> <p><b>Are the data 'rich'?</b> Mixed. It's not always clear whether the response is from an Early Supported Discharge patient or from someone who has been discharged without the Early Supported Discharge service. The themes applied to the data are useful and seem appropriate. However</p>	<p>participation was voluntary and all information would be treated in confidence. The study was approved by the Nottingham Research Ethics Committee 1, and written informed consent was obtained from all patients and identified carers.</p> <p><b>Were service users involved in the study?</b> No.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. Although according to the NAIC definition, single condition Early Supported Discharge should be outside of scope. The reviewers agreed to include this paper because the GC were not happy to exclude Early Supported Discharge interventions outright. The evidence from this paper will be presented at the GC can discuss whether they think it is appropriate as a basis for recommendations.</p>	<p><b>Overall validity rating:</b> +</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>there isn't an awful lot of data presented.</p> <p><b>Is the analysis reliable?</b> Somewhat reliable. A second researcher reviewed the interview transcripts and checked the relevance of each theme. Differences in research perspective were discussed and agreement was reached. Cases disconfirming the core themes were examined and reported. However, participants were not given the opportunity to feedback on interview transcripts.</p> <p><b>Are the findings convincing?</b> Somewhat convincing. The findings are fairly clearly presented although it is not always easy to tell whether data from Early Supported Discharge patients or non-Early Supported Discharge patients are being reported. Findings seem internally coherent albeit that</p>	<p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. Community services provided in peoples own homes.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. With the caveat that this is Early Supported Discharge (outside the NAIC definition).</p> <p><b>(For views questions) Are the views and experiences reported relevant to the guideline?</b> Yes.</p> <p><b>Does the study have a UK perspective?</b> Yes. The study was conducted in Nottinghamshire, UK.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>there are some contrasting views. Extracts from the original data are included and well referenced. Reporting is coherent and fairly clear.</p> <p><b>Are the conclusions adequate?</b> Adequate. There are clear links between the data, interpretation and conclusions. The conclusions are plausible and coherent. Implications of the research are clearly defined and also summarized in a 'clinical messages' summary at the end. There is adequate discussion of the study limitations.</p>		

**3. McLeod E, Bywaters P, Tanner D et al. (2008) For the sake of their health: Older service users' requirements for social care to facilitate access to social networks following hospital discharge. British Journal of Social Work 38: 73-90**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Is a qualitative approach appropriate?</b> Somewhat appropriate. The data were gathered via postal survey and telephone interview (mainly postal survey). It is likely that</p>	<p><b>Is the context clearly described?</b> Clear. The context (the 5 hospital aftercare social rehabilitation projects) was described although there but there is no</p>	<p><b>Does the study's research question match the review question?</b> Partly. The paper explores the forms of social care that older service users require after hospital</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b></p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>this was due to resource limitations but face to face interviews would have been a more reliable way of gathering data about people's experiences of rehabilitation post discharge.</p> <p><b>Is the study clear in what it seeks to do?</b> Clear. To understand people's experiences and views relating to the post hospital social rehabilitation services.</p> <p><b>How defensible/rigorous is the research design/methodology?</b> Somewhat defensible. The design is somewhat appropriate to the research question, although the use of face to face interviews would have improved the reliability and arguably the richness of the findings. There are clear accounts of the rationale/justification for the sampling although it is a limitation that project co-ordinators carried out the</p>	<p>description of how context bias was minimised.</p> <p><b>Was the sampling carried out in an appropriate way?</b> Appropriate. The risk of sampling bias (where for example, only people happy with the service might be sampled) was minimised because the sample was randomly selected - albeit by project coordinators. It wasn't purposefully stratified and the target number was chosen to ensure participants from all 5 projects participated.</p> <p><b>Were the methods reliable?</b> Somewhat reliable. The methods do investigate what they claim to and more than 1 method of data collection was used, which is to the study's credit. However, the opportunity was missed to triangulate the collected data. For example, the analysis of user case records could have been matched with the</p>	<p>discharge, to facilitate access to or re-engagement in social networks. It does this by drawing on a qualitative study of pilot voluntary sector hospital aftercare social rehabilitation projects.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. All participants gave informed, written consent. There is no mention of gaining ethical approval for the study.</p> <p><b>Were service users involved in the study?</b> Yes. To reflect older service users' interests and perspectives, a representative from an Older Service Users' Health and Social Care Forum contributed to all aspects of the research design and process.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The focus is on delivering social</p>	<p>++</p> <p><b>Overall validity rating:</b> +</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>random sampling - there is no reference to whether this process was blinded or could have been selective. The fact that interviews with project coordinators were conducted is positive and allowed for triangulation. There is no description of the analysis of survey data.</p> <p><b>How well was the data collection carried out?</b> Somewhat appropriately. Appropriate data were collected to address the research question but stronger data would have been provided if the service records could have matched with the interviewees/ questionnaire respondents. Data collection is described quite clearly although the description of the sampling of service records refers to 'vagaries in selection' to explain why fewer records were analysed that had been the aim. There is no description of record keeping in relation to</p>	<p>interview/ questionnaire data, which in turn could have been triangulated with the interview data from the 5 project coordinators.</p> <p><b>Are the data 'rich'?</b> Rich. The detail of the data was demonstrated and responses were compared and contrasted across the 5 projects. Findings were backed with quotes, which were connected with the contexts (e.g. the projects).</p> <p><b>Is the analysis reliable?</b> Unreliable. We are told that all data were analysed thematically in relation to specific research objectives although this thematic analysis is not described. There is also no evidence that more than 1 researcher themed and code transcripts/data. There is no suggestion that participants' feedback on the transcripts/data. Finally, the</p>	<p>rehabilitation in the context of a hospital discharge service.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. Although older rather than younger adults.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. Delivered in people's own homes.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. Post hospital rehabilitation with a limited duration, delivered in people's own homes.</p> <p><b>(For views questions) Are the views and experiences reported relevant to the guideline?</b> Yes.</p> <p><b>Does the study have a UK</b></p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>data collection.</p>	<p>authors do not present discrepant results and although this could mean there were no such results, it could also suggest they were ignored in the analysis.</p> <p><b>Are the findings convincing?</b> Convincing. Extracts from the original data are included, with appropriately referencing. The reporting, organised in themes is clear and coherent and it is also contextualised with existing literature.</p> <p><b>Are the conclusions adequate?</b> Adequate. The findings are clearly relevant to the aims of the study and there are good links between data, interpretation and conclusions. The conclusions are plausible and coherent and are linked to existing research. They enhance understanding of the ways in which social rehabilitation can be effectively provided via a</p>	<p><b>perspective?</b> Yes. '5 UK localities'.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	hospital aftercare service. The only drawback is that study limitations are not discussed in any detail except to say that study is 'small scale'.		

**4. Mitchell F, Dobson C, McAlpine A et al. (2011) Intermediate care: Lessons from a demonstrator project in Fife. Journal of Integrated Care 19(1): 26-36**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Is a qualitative approach appropriate?</b> Appropriate.</p> <p><b>Is the study clear in what it seeks to do?</b> Mixed. There is some reference to existing literature. Although the purpose of the overall demonstrator project is fairly clear, it is not immediately obvious how the service user interviews fit in and how they contribute.</p> <p><b>How defensible/rigorous is the research design/methodology?</b> Somewhat defensible. There's no clear account of the rationale for sampling and no account of</p>	<p><b>Is the context clearly described?</b> Unclear. There's no information about the characteristics of the participants and we don't know who conducted the interviews e.g. whether a provider of the service or an independent researcher.</p> <p><b>Was the sampling carried out in an appropriate way?</b> Somewhat appropriate. A random sample of 12 of the 34 intermediate care participants were invited to participate however we have no idea about the sampling frame for the staff survey and do not know the response rate.</p>	<p><b>Does the study's research question match the review question?</b> Yes. The intermediate care demonstrator project (which increased the availability of access to the existing intermediate care services in 1 locality in Fife) involved face to face interviews with patients about their experience of intermediate care.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> No. Not reported.</p>	<p><b>Overall assessment of internal validity:</b> -</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> -</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>the analysis of the interview data.</p> <p><b>How well was the data collection carried out?</b> Inappropriately. Face to face interviews are appropriate for understanding people's experiences of the intermediate care service. However data collection methods are not clearly described except to say that interviews were conducted in people's own homes. There's also no description of any systematic recording of the interviews. We're told that 18 staff completed a survey but we do not know the size of the sampling frame or the number of people who were invited to respond to the survey. We therefore do not know what the response rate was or whether the respondents are representative.</p>	<p><b>Were the methods reliable?</b> Somewhat reliable. The service user data were not collected in any way except via interviews - no observation and the outcomes data (numbers remaining at home, numbers returning home) were not linked with the interview data for example. However, the authors do describe their findings alongside other studies. Staff views were gathered via questionnaires although there is mention of 6 interviews taking place - but it is not clear how these relate to the 18 survey respondents.</p> <p><b>Are the data 'rich'?</b> Poor. There's no information about the context of the data and we have no idea about the diversity of perspective represented by the participants. Results are presented with very little detail.</p>	<p><b>Were service users involved in the study?</b> No.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. People using intermediate care.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes.</p> <p><b>(For views questions) Are the views and experiences reported relevant to the guideline?</b> Yes.</p> <p><b>Does the study have a UK perspective?</b> Yes. Conducted in Scotland.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Is the analysis reliable?</b> Unreliable. There is no information to suggest that more than one researcher themed and coded transcripts/data. Also no information to suggest that participant's feedback on the transcripts/data. There's no evidence of discrepant results. The results are presented more or less as a consensus.</p> <p><b>Are the findings convincing?</b> Somewhat convincing. The findings seem convincing but are only illustrated with the use of 1 quote.</p> <p><b>Are the conclusions adequate?</b> Inadequate. The conclusions are not in-depth and certain statements are made which are not backed by the data provided e.g. 'The results provide strong evidence that the service enabled patients to return to</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	their previous level of ability in activities of daily living' (p30).		

**5. Townsend J, Godfrey M, Moore J (2006) Careful thoughts: Recognising and supporting older carers in intermediate care. Research Policy and Planning 24(1): 39-52**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Is a qualitative approach appropriate?</b> Appropriate. A qualitative approach was appropriate for exploring the aims of the study.</p> <p><b>Is the study clear in what it seeks to do?</b> Clear. The aims of the study are clearly outlined and referred to in the literature.</p> <p><b>How defensible/rigorous is the research design/methodology?</b> Defensible. The rationales for the research design, data collection and data analysis techniques are provided.</p> <p><b>How well was the data collection carried out?</b> Appropriately. The data collection methods are clearly</p>	<p><b>Is the context clearly described?</b> Clear. The characteristics of the participants and settings are clearly defined. The authors considered the influence of the setting where the study took place.</p> <p><b>Was the sampling carried out in an appropriate way?</b> Somewhat appropriate. The sample focused mainly on traditional dyadic relationships, and carers who were immediately 'visible' (i.e. the perspectives of others providing informal support such as friends and neighbours were not explored). Service users were also predominantly women.</p>	<p><b>Does the study's research question match the review question?</b> Yes. The study's research question clearly relates to the review question.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. The study had ethics committee permission.</p> <p><b>Were service users involved in the study?</b> Yes. Service users were involved as participants and not in the design or interpretation of results.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study clearly relates to intermediate care.</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>described and seem appropriate to address the research question.</p>	<p><b>Were the methods reliable?</b> Somewhat reliable. The data was not collected by more than 1 method, but the authors do discuss their findings alongside other studies.</p> <p><b>Are the data ‘rich’?</b> Rich. The contexts of the data are clearly described, the diversity of perspective and content was explored, and detail of the data was demonstrated - supported by data extracts.</p> <p><b>Is the analysis reliable?</b> Somewhat reliable. The authors note that, during data analysis, there was 'discussion within the team', however, no other reliability checks are reported.</p> <p><b>Are the findings convincing?</b> Convincing. Extracts from the original data are included and the data is appropriately referenced. The</p>	<p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. The study population consists of people using intermediate care services and their carers.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. The study was conducted following participants' discharge from intermediate care.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. Study interviews explored user and carer views on intermediate care service experiences and outcomes.</p> <p><b>(For views questions) Are the views and experiences reported relevant to the guideline?</b> Yes. Views and</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>reporting is clear and coherent.</p> <p><b>Are the conclusions adequate?</b> Adequate. The conclusions are plausible and coherent, and implications of the research are clearly outlined. There is adequate discussion of the limitations of the study.</p>	<p>experiences reported are relevant to the guideline topic.</p> <p><b>Does the study have a UK perspective?</b> Yes. UK study.</p>	

## Review question 1 – Critical appraisal – Health, social care and other practitioners’ views and experiences

### 1. Chouliara N, Fisher RJ; Kerr M et al. (2014) Implementing evidence-based stroke Early Supported Discharge services: A qualitative study of challenges, facilitators and impact. *Clinical Rehabilitation* 28: 370-7

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Is a qualitative approach appropriate?</b> Appropriate. The study aims to determine the views of healthcare professionals and commissioners.</p> <p><b>Is the study clear in what it seeks to do?</b> Clear. The study has a clear objective and this is</p>	<p><b>Is the context clearly described?</b> Unclear. Only minimal detail in relation to the characteristics of participants and the context in which the data were collected are provided.</p> <p><b>Was the sampling carried out in an appropriate way?</b></p>	<p><b>Does the study’s research question match the review question?</b> Partly. The study reports the results of interviews with health professionals and commissioners working with a stroke Early Supported Discharge service; and aims to describe their views on the</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p>The lack of detail in relation to contexts and participants, and the fact that data was only collected by 1 method means that it is not possible</p>

<p>discussed in relation to the relevant literature.</p> <p><b>How defensible/rigorous is the research design/methodology?</b> Defensible. The authors provide a rationale for the use of a qualitative approach and the design is appropriate (semi-structured interviews), however there is not a great deal of discussion in relation to choice of sampling method or data collection and analysis techniques.</p> <p><b>How well was the data collection carried out?</b> Appropriately.</p>	<p>Somewhat appropriate. Detail in relation to sampling is minimal however this appears to be appropriate (purposive sampling of 'key' stakeholders at each site).</p> <p><b>Were the methods reliable?</b> Somewhat reliable. Data collected by interviews only – not triangulated.</p> <p><b>Are the data 'rich'?</b> Mixed. Although there are a good amount of verbatim quotes, discussion of different perspectives, and comparisons made between the 2 sites/teams only minimal detail is provided in relation to the context of the data.</p> <p><b>Is the analysis reliable?</b> Reliable. Data were analysed by 2 researchers to identify common themes and discrepancies. Participant verification is not reported.</p> <p><b>Are the findings convincing?</b> Convincing. The findings are coherent and</p>	<p>impact of the service and the factors which '... facilitate or impede the implementation of the service' (p370). The study was included by the NCCSC as the service as described in the paper seemed to clearly align with the definition of intermediate care used by the review team despite the exclusion of these services from the National Audit of Intermediate Care.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Partly. Participants gave informed consent; however approval for the study is not reported.</p> <p><b>Were service users involved in the study?</b> No. No indication that service users were involved in the design of the study or interpretation of findings.</p> <p><b>Is there a clear focus on the guideline topic?</b> Partly. The study focuses on 2 stroke Early Supported Discharge</p>	<p>to award a higher quality rating.</p> <p><b>Overall assessment of external validity:</b> +</p> <p><b>Overall validity rating:</b> +</p>
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	<p>clearly presented and are supported with a good number of verbatim quotes which are appropriately referenced.</p> <p><b>Are the conclusions adequate?</b> Somewhat adequate. The conclusions are generally adequate however the findings mostly focus on the perceived impact of the service rather than identifying barriers and facilitators to implementation which was also an objective of the study. The authors do not really discuss limitations associated with the study although they note that the research was conducted at an early stage in the development of both teams. There is some discussion of the findings/conclusion in relation to other research.</p>	<p>services which appear to be equivalent to the NCCSC working definition of intermediate care.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Partly. The study reports on interviews with health professionals and commissioners who work with stroke Early Supported Discharge services.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Partly. Setting not reported.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Partly. The study focuses on 2 stroke Early Supported Discharge services, both of which appear to include short-term multi-disciplinary rehabilitation in the service users own home which aligns with the NCCSC's working</p>	
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		<p>definition of home based intermediate care.</p> <p><b>(For views questions) Are the views and experiences reported relevant to the guideline?</b> Partly. The study reports the views of professionals in relation to 2 stroke Early Supported Discharge services.</p> <p><b>Does the study have a UK perspective?</b> Yes. The study was conducted in England.</p>	
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**2. Glasby J, Martin G, Regen E (2008) Older people and the relationship between hospital services and intermediate care: Results from a national evaluation. Journal of Interprofessional Care 22: 639-49**

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p><b>Is a qualitative approach appropriate?</b> Appropriate. The study aims to determine the views of key professionals on the benefits of intermediate care and the challenges of implementing intermediate care services.</p> <p><b>Is the study clear in what it seeks to do?</b> Clear. The objective of the study is clear</p>	<p><b>Is the context clearly described?</b> Unclear. Very little detail in relation to the characteristics of participants and context are provided. The authors note that data is presented by site rather than professional background of the respondent in order to ensure anonymity however it is therefore difficult to make useful distinctions such as</p>	<p><b>Does the study's research question match the review question?</b> Partly. The study is part of a national evaluation of intermediate care and aims to '... explore the views of intermediate care leads on the benefits and challenges of implementing intermediate care policy' (p642). The specific focus of the paper is to explore the links between</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p>The lack of detail on context and participants; and the sampling of 'key' managers and practitioners means that it is not possible to award a higher score.</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>and there is a good discussion of relevant literature.</p> <p><b>How defensible/rigorous is the research design/methodology?</b> Somewhat defensible. Whilst the study design (interviews and focus groups) is appropriate the authors do not present their rationale for this approach. Although the authors do discuss their approaches to data collection and analysis only minimal detail is provided in relation to the sampling strategy and it is not clear on what basis 'key' managers and practitioners were selected.</p> <p><b>How well was the data collection carried out?</b> Appropriately. The data collection and management methods are clearly described and are appropriate to address the research question.</p>	<p>whether managers and practitioners differed in their viewpoints and it could be argued that this type of information would not compromise anonymity.</p> <p><b>Was the sampling carried out in an appropriate way?</b> Not sure. Although there is a good amount of detail in relation to the selection of the case study sites at which participants in this study were based, it is not clear how 'key' managers or practitioners at these sites were selected.</p> <p><b>Were the methods reliable?</b> Somewhat reliable. Data was collected via interviews and focus groups however the authors do not contextualise their findings in relation to other research.</p> <p><b>Are the data 'rich'?</b> Mixed. Although there are a good amount of verbatim quotes there is only minimal detail</p>	<p>intermediate care and acute care.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Partly. The authors do not report approval for the study; however written consent was obtained before interviews took place.</p> <p><b>Were service users involved in the study?</b> No. No indication that service users were involved in the design of the study or the interpretation of findings.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study focuses on intermediate care.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. The study reports the views of key professionals involved in the</p>	<p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>provided in relation to the context of the data and there is little exploration of diversity of perspective or comparisons between sites.</p> <p><b>Is the analysis reliable?</b> Somewhat reliable. Although key themes identified in the analysis were discussed at research team meetings the authors do not report that double coding, discussion of discrepancies, or participant verification took place.</p> <p><b>Are the findings convincing?</b> Somewhat convincing. The findings are clearly presented and there are an appropriate number of verbatim quotes however the findings are not very detailed. The lack of information in relation to context means that it is particularly difficult to draw any meaningful conclusions from the study.</p> <p><b>Are the conclusions adequate?</b> Adequate.</p>	<p>delivery, management and planning of intermediate care services across 5 sites.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Partly. Although settings are not reported by the study it seems likely that the settings in which the services operate will correspond to those outlined in the scope.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. Service organisation.</p> <p><b>(For views questions) Are the views and experiences reported relevant to the guideline?</b> Yes. The study reports the views of key professional stakeholders working in intermediate care.</p> <p><b>Does the study have a UK perspective?</b> Yes.</p>	

## Review question 1 – Critical appraisal – additional effectiveness data

1. Aimonino N, Tibaldi V, Barale S et al. (2007) Depressive symptoms and quality of life in elderly patients with exacerbation of chronic obstructive pulmonary disease or cardiac heart failure: Preliminary data of a randomized controlled trial. *Archives of Gerontology and Geriatrics*. 44 (Suppl. 1): 7-12

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To evaluate mortality, functional, cognitive, affective status in elderly patients (&lt;75 years of age) with chronic obstructive pulmonary disease or acute congestive heart failure when treated at home or in a general ward after admission to emergency department.</p> <p><b>Description of theoretical approach?</b> No.</p> <p><b>How was selection bias minimised?</b> Randomised.</p> <p><b>Was the allocation method concealed?</b> Not reported.</p> <p><b>Were participants blinded?</b> Not reported.</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Not reported.</p> <p><b>Was contamination acceptably low?</b> Not reported.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> Not reported.</p> <p><b>Were outcomes relevant?</b> Yes.</p> <p><b>Were outcome measures reliable?</b> Yes. Activities of Daily Living, Instrumental Activities of Daily Living, Mini Mental state examination, Geriatric Depression Scale, Mini Nutritional Assessment,</p>	<p><b>Does the study's research question match the review question?</b> <b>Partly.</b> Focused on home hospital service vs. a general medical ward service after emergency admission.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> No.</p> <p><b>Were service users involved in the design of the study?</b> No.</p> <p><b>Is there a clear focus on the guideline topic?</b> Partly. Focus on diagnostic and therapeutic treatments by health care professionals in patient's home. Not explicitly intermediate care.</p>	<p><b>Overall assessment of internal validity:</b> -</p> <p><b>Overall assessment of external validity:</b> +</p> <p><b>Overall validity rating:</b> +</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Were providers blinded?</b> Not reported.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Not reported.</p> <p><b>Did participants represent the target group?</b> Yes.</p> <p><b>Were all participants accounted for at study conclusion?</b> Not reported.</p>	<p>Acute Physiology and Chronic Health Evaluation, Cumulative Illness Rating Scale, Nottingham Health Profile - quality of life, and Co-morbidity. Lengths of treatment, mortality, hospital readmission.</p> <p><b>Were all outcome measurements complete?</b> Partly. Only mortality, hospital readmission, lengths of treatment, GDS and NHP measured and reported.</p> <p><b>Were all important outcomes assessed?</b> Yes. Activities of Daily Living, Instrumental Activities of Daily Living, Geriatric Depression Scale, and Nottingham Health Profile measured and reported.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. Six months follow-up.</p>	<p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. Geriatric home service.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. Hospital treatment at home.</p> <p><b>(For effectiveness questions) Are the study outcomes relevant to the guideline?</b> Partly.</p> <p><b>Was the study conducted in the UK?</b> No. Italy.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Was follow-up time meaningful?</b> Not reported.</p> <p><b>Were the analytical methods appropriate?</b> Yes. Descriptive pre-post comparison.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Yes. No significant differences at baseline.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Not reported.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Not reported.</p> <p><b>Were the estimates of effect size given or calculable?</b> Not reported.</p> <p><b>Was the precision of intervention effects given or</b></p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>calculable? Were they meaningful? Not reported.</p> <p>Do conclusions match findings? Yes.</p>		

**2. Bjorkdahl A, Nilsson AL, Grimby G et al. (2006) Does a short period of rehabilitation in the home setting facilitate functioning after stroke? A randomized controlled trial. Clinical Rehabilitation 20: 1038-49**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To evaluate if 3 weeks of rehabilitation in the home setting of younger patients with stroke would improve activity than ordinary outpatient rehabilitation at the clinic and facilitate the rehabilitation process.</p> <p><b>Description of theoretical approach?</b> No.</p> <p><b>How was selection bias minimised?</b> Randomised. Methods Not reported.</p> <p><b>Was the allocation method concealed?</b> Yes. Sealed envelopes.</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Not reported.</p> <p><b>Was contamination acceptably low?</b> Not reported.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> Not reported.</p> <p><b>Were outcomes relevant?</b> Yes.</p> <p><b>Were outcome measures reliable?</b> Yes.</p>	<p><b>Does the study's research question match the review question?</b> Partly. Not specifically 'intermediate care', but addresses home rehabilitation after hospital discharge.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. Informed consent from participants; study approved by The Ethics Committee at Goteborg University.</p> <p><b>Were service users involved in the design of the study?</b> No</p>	<p><b>Overall assessment of internal validity:</b> ++</p> <p><b>Overall assessment of external validity:</b> +</p> <p><b>Overall validity rating:</b> +</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Were participants blinded?</b> Not reported.</p> <p><b>Were providers blinded?</b> Not reported.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Blind. Blinded assessors made all evaluations at discharge and after the intervention at 3 weeks as well as at additional follow-ups at 3 months and 1 year after discharge.</p> <p><b>Did participants represent the target group?</b> Yes. Stroke patients.</p> <p><b>Were all participants accounted for at study conclusion?</b> Yes. Two dropped out after randomisation.</p>	<p><b>Were all outcome measurements complete?</b> Yes.</p> <p><b>Were all important outcomes assessed?</b> Yes.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. At 3 weeks, 3 months and 1 year after discharge (post-intervention).</p> <p><b>Was follow-up time meaningful?</b> Yes.</p> <p><b>Were the analytical methods appropriate?</b> Yes. Also included power calculation.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Yes. The 2 groups did not differ significantly at discharge concerning age, gender, lateralization, proportion of</p>	<p><b>Is there a clear focus on the guideline topic?</b> Yes. Not specifically 'intermediate care', but addresses home rehabilitation after hospital discharge.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. Home setting.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. Home based rehabilitation.</p> <p><b>(For effectiveness questions) Are the study outcomes relevant to the guideline?</b> Yes. Functional activities.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>haemorrhages and infarcts, or in the results from any of the instruments used.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Yes.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Yes. Power analysis undertaken.</p> <p><b>Were the estimates of effect size given or calculable?</b> Yes. Mean and SDs.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Yes.</p> <p><b>Do conclusions match findings?</b> Yes.</p>	<p><b>Was the study conducted in the UK?</b> No. Sweden.</p>	

**3. Björkdahl A, Nilsson AL, Sunnerhagen KS (2007) Can rehabilitation in the home setting reduce the burden of care for the next-of-kin of stroke victims? Journal of Rehabilitation Medicine 39: 27-32**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To evaluate if an intervention with information about stroke and its consequences, as well as practical advice and training in the home setting reduces or affects the burden of care for next-of-kin.</p> <p><b>Description of theoretical approach?</b> No</p> <p><b>How was selection bias minimised?</b> Randomised.</p> <p><b>Was the allocation method concealed?</b> Not reported.</p> <p><b>Were participants blinded?</b> Not reported.</p> <p><b>Were providers blinded?</b> Not reported.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Blind. Assessors</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Partly. Accessibility for the family at the clinic was not as easy as for the home group, and fewer opportunities were given to ask questions and get direct answers in conjunction with the training.</p> <p><b>Was contamination acceptably low?</b> Not reported.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> Not reported.</p> <p><b>Were outcomes relevant?</b> Yes.</p> <p><b>Were outcome measures reliable?</b> Yes. Caregiver burden scale.</p>	<p><b>Does the study's research question match the review question?</b> Yes.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. The Ethics Committee at Göteborg University approved the study.</p> <p><b>Were service users involved in the design of the study?</b> No.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. Carer's burden.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. Family carers.</p> <p><b>Is the study setting the same as at least one of the settings covered by the</b></p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> +</p> <p><b>Overall validity rating:</b> +</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>were blind when evaluating outcomes.</p> <p><b>Did participants represent the target group?</b> Yes. Family carers of stroke patients.</p> <p><b>Were all participants accounted for at study conclusion?</b> No. Response rate 80%.</p>	<p><b>Were all outcome measurements complete?</b> Yes.</p> <p><b>Were all important outcomes assessed?</b> Yes.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. At 3 weeks, 6 months and 1 year.</p> <p><b>Was follow-up time meaningful?</b> Yes.</p> <p><b>Were the analytical methods appropriate?</b> Yes.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Not reported.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> No.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Not reported.</p>	<p><b>guideline?</b> Yes. Home vs. clinic.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. Rehabilitation in the home setting.</p> <p><b>(For effectiveness questions) Are the study outcomes relevant to the guideline?</b> Yes.</p> <p><b>Was the study conducted in the UK?</b> No. Sweden.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Were the estimates of effect size given or calculable?</b> Not reported.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Partly.</p> <p><b>Do conclusions match findings?</b> Yes.</p>		

**4. Fjaertoft H, Indredavik B, Magnussen J et al. (2005) Early supported discharge for stroke patients improves clinical outcome. Does it also reduce use of health services and costs? One-year follow-up of a randomized controlled trial. Cerebrovascular diseases 19: 376-83**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To compare the use of health services and the costs of these in the extended stroke unit service group with the ordinary stroke unit service group during the first year following a stroke.</p> <p><b>Description of theoretical approach?</b> No.</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Not reported.</p> <p><b>Was contamination acceptably low?</b> Not reported.</p> <p><b>Did either group receive additional interventions or have services provided in a</b></p>	<p><b>Does the study's research question match the review question?</b> Yes. Early supported discharge.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. The Regional Committee on Medical Research Ethics evaluated the study protocol and approved the trial.</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> +</p> <p><b>Overall validity rating:</b> +</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>How was selection bias minimised?</b> Randomised. Permuted blocks with random number tables.</p> <p><b>Was the allocation method concealed?</b> Yes. Permuted blocks with random number tables provided in sealed opaque envelopes.</p> <p><b>Were participants blinded?</b> Not reported.</p> <p><b>Were providers blinded?</b> Not reported.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Not reported.</p> <p><b>Did participants represent the target group?</b> Yes.</p> <p><b>Were all participants accounted for at study conclusion?</b> Yes.</p>	<p><b>Internal validity - performance and analysis different manner?</b> Not reported.</p> <p><b>Were outcomes relevant?</b> Yes.</p> <p><b>Were outcome measures reliable?</b> Yes.</p> <p><b>Were all outcome measurements complete?</b> Yes.</p> <p><b>Were all important outcomes assessed?</b> Yes.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes.</p> <p><b>Was follow-up time meaningful?</b> Yes.</p> <p><b>Were the analytical methods appropriate?</b> Yes.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were</b></p>	<p>Patient consent obtained (Indredavik 2000).</p> <p><b>Were service users involved in the design of the study?</b> No.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. Early supported discharge.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. Home.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. Early supported discharge, home based rehabilitation.</p> <p><b>(For effectiveness questions) Are the study</b></p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>these adjusted?</b> Yes. There were no significant differences between the groups.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Yes.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Not reported. Follow-up of a previous study by Indredavik 2000.</p> <p><b>Were the estimates of effect size given or calculable?</b> Not reported.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Not reported.</p> <p><b>Do conclusions match findings?</b> Yes.</p>	<p><b>outcomes relevant to the guideline?</b> Yes.</p> <p><b>Was the study conducted in the UK?</b> No. Norway.</p>	

**5. Inglis SC, Pearson S, Treen S et al. (2006) Extending the horizon in chronic heart failure: Effects of multidisciplinary, home-based intervention relative to usual care. Circulation 114: 2466-73**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To examine the long-term (minimum of 7.5 to 10 years) impact of a nurse-led, multidisciplinary home based intervention versus usual post-discharge care in an old and fragile cohort of 297 congestive heart failure patients discharged from short-term hospital care.</p> <p><b>Description of theoretical approach?</b> Yes. Application of a broad range of adult learning theories relating to life-long learning, and the principles of individual and community empowerment to facilitate self-determination and self-care.</p> <p><b>How was selection bias minimised?</b> Randomised. Used a blinded computerised protocol (info from Stewart 2002).</p> <p><b>Was the allocation method concealed?</b> Not reported.</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Yes.</p> <p><b>Was contamination acceptably low?</b> Not reported.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> Partly. In the previous study (follow-up at 3 years, Stewart 2002), 7 patients received repeat home visits if they survived a readmission within 6 months.</p> <p><b>Were outcomes relevant?</b> Yes.</p> <p><b>Were outcome measures reliable?</b> Yes.</p> <p><b>Were all outcome measurements complete?</b> Yes.</p>	<p><b>Does the study's research question match the review question?</b> Partly. Not specifically 'intermediate care', but focused on home based management of congestive heart failure after hospital discharge.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. Patients signed a consent form (information from Stewart 2002).</p> <p><b>Were service users involved in the design of the study?</b> No.</p> <p><b>Is there a clear focus on the guideline topic?</b> Partly. Did not specify 'intermediate care' but addressed a home based intervention for chronic disease management of congestive heart failure after hospital discharge. Duration</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> +</p> <p><b>Overall validity rating:</b> +</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Were participants blinded?</b> Not reported.</p> <p><b>Were providers blinded?</b> Not reported.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Blind. Outcomes examined in a blinded manner.</p> <p><b>Did participants represent the target group?</b> Yes.</p> <p><b>Were all participants accounted for at study conclusion?</b> Yes.</p>	<p><b>Were all important outcomes assessed?</b> Yes.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes.</p> <p><b>Was follow-up time meaningful?</b> Yes. Long-term impact measured at ten years after intervention.</p> <p><b>Were the analytical methods appropriate?</b> Yes.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Yes. At baseline, home based intervention patients were more likely to have a prior acute myocardial infarction, left bundle-branch block, and higher blood urea concentration.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Yes.</p>	<p>of intervention not reported but patients followed up over 6 months.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. Home-based intervention.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. Nurse-led, multi-disciplinary, home-based intervention.</p> <p><b>(For effectiveness questions) Are the study outcomes relevant to the guideline?</b> Yes.</p> <p><b>Was the study conducted in the UK?</b> No. Australia.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Not reported.</p> <p><b>Were the estimates of effect size given or calculable?</b> Yes.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Yes.</p> <p><b>Do conclusions match findings?</b> Yes.</p>		

**6. Kalra L, Evans A, Perez I et al. (2005) A randomised controlled comparison of alternative strategies in stroke care. Health Technology Assessment 9: 18**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To compare a range of outcomes at 3, 6 and 12 months between stroke patients managed on the stroke unit, on general wards with stroke team support or at home by specialist domiciliary care team.</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Yes.</p> <p><b>Was contamination acceptably low?</b> Not reported.</p> <p><b>Did either group receive additional interventions or</b></p>	<p><b>Does the study's research question match the review question?</b> Yes. Stroke care and management at home after discharge.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. The</p>	<p><b>Overall assessment of internal validity:</b> ++</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b></p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Description of theoretical approach?</b> Partly.</p> <p><b>How was selection bias minimised?</b> Randomised. Randomisation was unstratified using the block randomisation technique, in 16 blocks of 30.</p> <p><b>Was the allocation method concealed?</b> Yes. Randomisation was conducted in an office remote from patient treatment areas, so that it would not be possible for those enrolling patients to guess allocation for the vast majority of subjects.</p> <p><b>Were participants blinded?</b> Blinding not possible.</p> <p><b>Were providers blinded?</b> Not reported.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Blind. Independent observers were used for</p>	<p><b>have services provided in a different manner?</b> Not reported.</p> <p><b>Were outcomes relevant?</b> Yes.</p> <p><b>Were outcome measures reliable?</b> Yes.</p> <p><b>Were all outcome measurements complete?</b> Yes.</p> <p><b>Were all important outcomes assessed?</b> Yes.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. At 3, 6 and 12 months.</p> <p><b>Was follow-up time meaningful?</b> Yes.</p>	<p>project was approved by the local ethics committee.</p> <p><b>Were service users involved in the design of the study?</b> No</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. Domiciliary.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. Stroke care and management at home after discharge.</p> <p><b>(For effectiveness questions) Are the study</b></p>	<p>++</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>assessment and using outcome measures.</p> <p><b>Did participants represent the target group?</b> Yes.</p> <p><b>Were all participants accounted for at study conclusion?</b> No. Nine drop-outs in home care group; 3 in stroke team group.</p>	<p><b>Were the analytical methods appropriate?</b> Yes. Descriptive.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Yes. Baseline characteristics well matched across the 3 groups in stroke type and severity, level of impairment and initial disability.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Yes.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Yes. Power calculation conducted as part of design.</p> <p><b>Were the estimates of effect size given or calculable?</b> Yes.</p> <p><b>Was the precision of intervention effects given or</b></p>	<p><b>outcomes relevant to the guideline?</b> Yes.</p> <p><b>Was the study conducted in the UK?</b> Yes.</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
	<b>calculable? Were they meaningful? Yes.</b>  <b>Do conclusions match findings? Yes.</b>		

**Research question 2. Bed based intermediate care:**

- a) **What is the effectiveness and cost effectiveness of bed based intermediate care?**
- b) **What are the views and experiences of people using services, their families and carers in relation to bed based intermediate care?**
- c) **What are the views and experiences of health, social care and other practitioners about bed based intermediate care?**

**Research question 2 – Findings tables – Effectiveness**

**1. Crotty M, Whitehead CH, Wundke R et al. (2005) Transitional care facility for elderly people in hospital awaiting a long term care bed: Randomised controlled trial. British Medical Journal (Clinical Research Edition) 331: 1110-3**

<b>Research aims</b>	<b>PICO (population, intervention, comparison, outcomes)</b>	<b>Findings</b>	<b>Overall validity rating</b>
<p><b>Study aim:</b> To ‘... assess the effectiveness of moving patients who are waiting in hospital for a long term care bed to an off-site transitional care facility’ (p1).</p> <p><b>Methodology:</b> randomised controlled trial. Two arm randomised controlled trial using a Zelen randomised consent design.</p> <p><b>Country:</b> Not UK. Australia – South Adelaide.</p>	<p><b>Participants:</b> Service users and their families, partners and carers – Elderly patients admitted to acute care at 1 of 3 hospitals who were already awaiting placements in long-term care and had been assessed as ‘...unsuitable for other rehabilitation or community discharge support programmes’ (p1). The authors note that nearly 30% had been admitted to hospital as a result of ‘... musculoskeletal problems such as falls, fractures, and soft tissue</p>	<p><b>Statistical data – service user related outcomes - Care needs (measured using the Residential Care Scale):</b> Participants in the intervention group had a higher (worse) mean score on measures of care need, however this difference was not significant; control 55.6 (23.6 SD) vs. intervention 58.7 (22.0 SD), mean difference=-2.1 (95% Confidence Interval -8.3 to 4.1, p=0.506).</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p>Due to the very short follow-up period of 4 months and the fact that a number of participants were not transferred to the intervention facility as intended it is not possible to award a higher quality rating to this study.</p> <p><b>Overall assessment of external validity:</b> ++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Source of funding:</b> Government - South Australian Department of Human Services and Commonwealth Department of Health and Aged Care (National Demonstration Hospital Program Phase 4).</p>	<p>injuries' (p3), no further details on reasons for admission are reported.</p> <p>Patients were eligible '... if it was decided they were to go to long term care, an assessment had been performed, they were medically stable and ready for hospital discharge, and no long term care bed was available' (p1). Individuals with dementia or behavioural problems were eligible unless their care was thought to require additional staff.</p> <p>Patients appear to have been ineligible (although this is not clearly stated) if – discharge to another facility/location had already been arranged, if a long-term care placement had already been secured, if they were under the age of 65, and if the individual had no next of kin.</p>	<p>Functional level (measured using the modified Barthel index): Participants in the intervention group had a lower (worse) mean score on measures of physical function, however this difference was not significant; control 56.7 (27.2 SD) vs. intervention 55.2 (25.1 SD), mean difference = 1.5 (95% CI -5.6 to 8.6, p=0.678).</p> <p>Mortality: The proportion of participants who had died was higher in the intervention group than in the control group, however this difference was not significant; control n=28, 27% vs. intervention n=59, 28%, statistical data not provided, reported as non-significant by authors.</p> <p>Quality of life (measured using the Assessment of Quality of Life scale): Participants in the</p>	<p><b>Overall assessment of validity:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>Participants were referred by 1 of 3 referring hospitals, 1 of which provided services to veterans (no further details provided).</p> <p><b>Sample characteristics:</b>  Age – Participants under the age of 65 appear to have been excluded. Control group – mean age 83 years (7.2 SD); intervention group – mean age 82.8 years (8.3 SD).  Sex – Control group – male n=53 (51%); intervention group – male n=102 (48%).  Ethnicity – Not reported.  Religion/belief - Not reported.  Disability - Not reported.  Long term health condition - Not reported.  Socioeconomic position - Not reported.</p> <p><b>Sample size:</b>  Comparison numbers – Randomised n=108; received care as allocated n=105 (three participants withdrew after</p>	<p>intervention group had a higher (worse) mean score on measures of quality of life, however this difference was not significant; control 22.9 (4.9 SD) vs. intervention 24.0 (4.4 SD), mean difference = -1.1 (95% CI -2.3 to 0.2, p=0.099).</p> <p><b>Statistical data – service outcomes -</b>  Days in hospital from admission to discharge (one control participant not discharged from hospital in 4 month follow-up period): Participants in the intervention group spent significantly less time in hospital than those in the control group; control 43.5 days (95% CI 41.0 to 51.0) vs. intervention 32.5 days (95% CI 29.0 to 36.0), median difference in length of stay = 11 days (95% CI 6 to 16, p&lt;0.001).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>randomisation); assessed at four-month follow up n=77 (n=28 participants had died). Intervention numbers – Randomised n=212; received care as allocated n=134 (n=29 participants were transferred to a long-term care placement or died before transfer to intervention facility, n=44 declined transfer to intervention facility, n=5 were refused admission to intervention facility due to concerns regarding behaviour); assessed at four-month follow up n=153 (n=59 participants had died).</p> <p>Sample size – Randomised N=320; received care as allocated n=239; assessed at four-month follow up n=230.</p> <p><b>Intervention:</b> Intervention category - Bed based intermediate care. Describe intervention - The intervention is described by the authors as a ‘... transitional</p>	<p>Days in hospital from randomisation to discharge (one control participant not discharged from hospital in 4 month follow-up period): Participants in the intervention group spent significantly less time in hospital post-randomisation than those in the control group; control 16 days (13 to 20) vs. intervention 6 days (95% CI 5 to seven), median difference in post-randomisation length of stay = 10 days (95% CI 6 to 11, p&lt;0.001).</p> <p>Time from hospital admission to admission to permanent care (n=224): Of those participants who were admitted to permanent care (n=224), those in the intervention group took significantly longer to be admitted than those in the control group; control 51.5 days (95% CI 44.0 to 63.0)</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>care facility where all patients received a single assessment from a specialist elder care team and appropriate ongoing therapy' (p1). The care provided is described as multidisciplinary and aligned with a medical rehabilitation model.</p> <p>Delivered by - Care at the facility involves input from geriatricians, general practitioners, pharmacists, physiotherapists, rehabilitation medicine physicians, social workers, and 1 full-time transitional care nurse coordinator, as well as '... accommodation, catering, cleaning, nursing (5.0 full time equivalents in 24 hours), and carer staff (10.0 full time equivalents in 24 hours) ...' (p2).</p> <p>'Allied health' staff are reported to be equivalent to 4.4 full time members of staff; no further details in relation to staffing levels are provided. A private</p>	<p>vs. intervention 72.5 days (95% CI 62.0 to 81.9), median difference=-21 days (95% CI -27 to -6, p=0.003).</p> <p>Hospital use after randomization (combining initial length of stay post-randomisation and readmissions during the 4 month follow-up period) - Participants in the intervention group spent significantly less time in hospital during the total study period than those in the control group; control 18 days (95% CI 15 to 21) vs. intervention 7.5 days (95% CI 7.0 to 9.0), median difference=10.5 days (95% CI 6.0 to 11.0, p&lt;0.001).</p> <p>Proportion of participants readmitted to hospital over four-month follow-up period - The proportion of participants readmitted to hospital was higher in the intervention</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>long-term care provider and the 3 referring hospitals jointly staffed the facility.  Delivered to - Elderly patients waiting for long-term care placement and assessed as being '...unsuitable for other rehabilitation or community discharge support programmes' (p1).  Duration, frequency, intensity, etc. - Details in relation to the care provided are minimal. The median length of stay in the facility was 46 days (range 35.5 to 53.6 days), however 4 patients were still at the facility at the four-month follow-up.  The authors also report a maturation effect, with patients recruited during the second half of the study staying significantly longer in the facility, with a median stay of 28 days (21.3 to 46.7 days), in comparison to a median stay of 58 days (40.4 to 80.3 days) for patients recruited during the first half of the study (p=0.001).</p>	<p>group than in the control group but this difference was not significant; control 25% vs. intervention 28%, statistical data not provided, reported as non-significant by authors.  Participant status at follow-up (statistical testing of between group differences not reported for all statuses):  Permanent care - The proportion of participants living in permanent care was higher in the control group than in the intervention group (significance of between group differences not reported; control n=62, 59% vs. intervention n=104, 49%).  Home - The proportion of participants who were living in their own home was lower in the intervention group than in the control group however this difference was not significant (NB. Statistical data not provided, reported</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>Key components and objectives of intervention - The authors report that care provided at the facility was based on a model of medical rehabilitation which incorporated goal setting (including both the patient and their family), multidisciplinary assessment, and weekly case conferences). Patients were assessed by the whole team on admission, specialist medical staff took part in case conferences and reviewed admissions, and on-call medical care was available on a 24-hour basis. The transitional care nurse co-ordinator liaised with families and managed the transfer of case notes between the acute hospital and the transitional facility.</p> <p>Location/place of delivery - An offsite transitional 36 bed facility within 5-25km of 3 referring hospitals in South Adelaide, Australia.</p>	<p>as non-significant by authors).</p> <p>Died - Mortality was lower in the intervention group than in the control group, however this difference was not significant (NB. Statistical data not provided, reported as non-significant by authors).</p> <p>Transitional care facility - Twenty three participants in the intervention group were still staying in the transitional care facility (also reported in narrative as n=24, 11%).</p> <p>Hospital - The proportion of participants staying in hospital was the same in both groups (significance of between group differences not reported; control n=5, 5% vs. intervention n=10, 5%).</p> <p>Respite - The proportion of participants staying in respite care was the same in both groups (significance of between group differences</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p><b>Comparison intervention:</b> Participants in the control group received care as usual which was provided in the hospital. The authors note that these participants did not ‘... routinely receive specialist assessment from the geriatric or rehabilitation teams’ (p2). No further details provided.</p> <p><b>Outcomes measured:</b> Service user outcomes – Care needs were measured using the Residential Care Scale (0-104, lower scores correspond to lower levels of dependence). Functional level was measured using the modified Barthel index. (0-100, lower scores correspond to lower levels of physical function). Mortality (Source of data not reported). Quality of life was measured using the Assessment of Quality of Life scale (0-45,</p>	<p>not reported; control n=1, 1% vs. intervention n=2, 1%).</p> <p><b>Narrative findings - service user related outcomes -</b> Care needs (measured using the Residential Care Scale): Participants in the intervention group had a higher (worse) mean score on measures of care need, however this difference was not significant.</p> <p>Functional level (measured using the modified Barthel index): Participants in the intervention group had a lower mean score on measures of physical function, however this difference was not significant.</p> <p>Mortality: The proportion of participants who had died was higher in the intervention group than in the control group, however this difference was not significant</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>lower scores correspond to better quality of life).</p> <p>Service level outcomes – Hospital usage (days in hospital from admission to discharge). Source of data not reported.</p> <p>Hospital usage (days in hospital from randomisation to discharge). Source of data not reported.</p> <p>Hospital usage after randomisation (total length of stay – combining initial length of stay post-randomisation and readmissions during four-month follow-up period). Source of data not reported.</p> <p>Rate of returning home/participants living at home. Source of data not reported.</p> <p>Proportion of participants readmitted to hospital over follow-up period. Source of data not reported.</p> <p>Time from hospital admission to admission to permanent</p>	<p>(NB. Statistical data not provided, reported as non-significant by authors).</p> <p>Quality of life (measured using the Assessment of Quality of Life scale): Participants in the intervention group had a higher (worse) mean score on measures of quality of life, however this difference was not significant.</p> <p><b>Narrative findings - service outcomes –</b> Days in hospital from admission to discharge (one control participant not discharged from hospital in 4 month follow-up period): Participants in the intervention group spent significantly less time in hospital than those in the control group.</p> <p>Days in hospital from randomisation to discharge</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>care. Source of data not reported.</p> <p><b>Follow-up:</b> Both groups were followed-up for 4 months post-randomisation.</p>	<p>(one control participant not discharged from hospital in 4 month follow-up period): Participants in the intervention group spent significantly less time in hospital post-randomisation than those in the control group.</p> <p>Time from hospital admission to admission to permanent care (n=224): Of those participants who were admitted to permanent care (n=224), those in the intervention group took significantly longer to be admitted than those in the control group.</p> <p>Hospital use after randomization (combining initial length of stay post-randomisation and readmissions during the 4 month follow-up period): Participants in the intervention group spent significantly less time in</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>hospital during the total study period than those in the control group.</p> <p>Proportion of participants readmitted to hospital over four-month follow-up period: The proportion of participants readmitted to hospital was higher in the intervention group than in the control group but this difference was not significant (NB. Statistical data not provided, reported as non-significant by authors).</p> <p>Participant status at follow-up (statistical testing of between group differences not reported for all statuses): Permanent care - The proportion of participants living in permanent care was higher in the control group than in the intervention group (significance of between group differences not reported).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Home - The proportion of participants who were living in their own home was lower in the intervention group than in the control group however this difference was not significant (NB. Statistical data not provided, reported as non-significant by authors).</p> <p>Died - Mortality was lower in the intervention group than in the control group, however this difference was not significant (NB. Statistical data not provided, reported as non-significant by authors).</p> <p>Transitional care facility - Twenty three participants in the intervention group were still staying in the transitional care facility.</p> <p>Hospital - The proportion of participants staying in hospital was the same in both groups (significance of between group differences not reported).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		Respite - The proportion of participants staying in respite care was the same in both groups (significance of between group differences not reported).	

**2. Garåsen H, Windspoll R, Johnsen R (2007) Intermediate care at a community hospital as an alternative to prolonged general hospital care for elderly patients: A randomised controlled trial. BioMed Central Public Health 7: 68**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The aim of the study was to compare the efficacy of intermediate care at a community hospital with standard prolonged care at a general hospital.</p> <p><b>Methodology:</b> Randomised controlled trial.</p> <p><b>Country:</b> Norway.</p> <p><b>Source of funding:</b> Government - Central Norway Regional Health Authority.</p>	<p><b>Participants:</b> Service users and their families, partners and carers - Participants were service users.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Mean age of intervention group (randomised) = 80.6 Mean age of intervention group (received intervention) = 80.9 Mean age of comparison group = 81.3.</li> <li>• Sex - Intervention group (randomised) = 20 males / 52 females Intervention</li> </ul>	<p><b>Statistical data – service outcomes –</b></p> <p>Readmissions - Of the 72 patients in the Intervention group, 14 (19.4%) were readmitted for the same disease within 60 days, while 25 out of 70 (37.5%) from the control group receiving general hospital treatment were readmitted. Of the Intervention group readmissions, 9 (64.3%) took place before they had been discharged home, while from the general hospital group 19</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>group (received intervention) = 14 males / 50 females Comparison group = 27 males / 43 females.</p> <ul style="list-style-type: none"> <li>• Ethnicity – Not reported.</li> <li>• Religion/belief – Not reported.</li> <li>• Disability – Not reported.</li> <li>• Long term health condition - The most common primary diagnosis was cardiological diseases: Intervention group (randomised) = 22 Intervention group (received intervention) = 21 Comparison group = 20. Other reported conditions included infections, fractures/contusions, pulmonary diseases, neurological diseases, cancers, psychiatric diseases and other diseases.</li> <li>• Sexual orientation – Not reported.</li> </ul>	<p>(76.0%) were readmitted after discharge and 6 (24%) during rehabilitation care. Odds Ratio (OR) for readmissions for the same disease in the intervention group versus the general hospital group was 2.77 (95% CI 1.18–6.49). There was statistically a significant difference between the two groups (p=0.03 while p adjusted for age, gender, ADL and diagnosis was 0.02).</p> <p>Use of nursing home or home care - There were no significant differences in need for nursing homes and home care after 6 months, with 38 (52.8%) from the intervention and 44 (62.9%) from the comparison group still needing long-term home nurse care. The OR for the need of home care was 1.21 (95% CI 0.59–2.52) in the intervention group versus the general hospital group.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Socioeconomic position – Not reported.</li> </ul> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers - n=70.</li> <li>• Intervention numbers – randomised n=72; received intervention n=64.</li> <li>• Sample size – Total N=142.</li> </ul> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Bed based intermediate care.</li> <li>• Describe intervention - The intervention was based on individualised intermediate care, focussing on improving physical functioning so that participants would be able to manage independently on returning home.</li> <li>• Delivered by - The intervention was delivered by the multi-disciplinary team.</li> <li>• Delivered to - The intervention was delivered to service users who had been</li> </ul>	<p>Numerically and proportionately there were more in the intervention group who were independent of home care (18 participants, 25%) than in the general hospital group (7 participants, 10%). The OR was 0.31 (95% CI 0.11–0.88) in favour of the intervention group.</p> <p><b>Narrative findings - service outcomes -</b>  Participants who received intermediate care had better outcomes than those receiving standard care, with significantly fewer readmissions. Although statistically insignificant, results favour intermediate care with regards to decreased mortality and need for community care at 6 month follow-up.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>admitted to hospital due to acute illness/exacerbation of chronic disease and were subsequently randomised to the intermediate care condition.</p> <ul style="list-style-type: none"> <li>• Duration, frequency, intensity, etc. - This is not reported, however, the authors do note that the intervention was individualised to each participant.</li> <li>• Key components and objectives of intervention - The main objective of the intervention was to improve physical functioning so that participants would be able to manage independently on returning home.</li> <li>• Content/session titles - N/A.</li> <li>• Location/place of delivery - The intervention took place at a community hospital.</li> </ul> <p><b>Comparison intervention:</b> The comparison intervention was standard prolonged care</p>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>at a general hospital, where normal routines were followed. No further information is provided.</p> <p><b>Outcomes measured:</b> Service user related outcomes</p> <ul style="list-style-type: none"> <li>• Mortality.</li> </ul> <p>Service outcomes</p> <ul style="list-style-type: none"> <li>• Number of days in institution, readmissions were assessed through patients' journals and health records, as well as administrative systems.</li> </ul> <p><b>Follow-up:</b> Participants were followed up for 6 months (approximately 26 weeks after baseline).</p> <p><b>Costs?</b> No.</p>		

**3. Garåsen H, Windspoll R, Johnsen R (2008) Long-term patients' outcomes after intermediate care at a community hospital for elderly patients: 12-month follow-up of a randomized controlled trial. Scandinavian Journal of Public Health 36: 197-204**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The aim of the study was to compare the efficacy of intermediate care at a community hospital with standard prolonged care at a general hospital.</p> <p><b>Methodology:</b> Randomised controlled trial.</p> <p><b>Country:</b> Norway.</p> <p><b>Source of funding:</b> Government - Central Norway Regional Health Authority.</p>	<p><b>Participants:</b> Service users and their families, partners and carers - Participants were service users.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Mean age of intervention group (randomised) = 80.6 Mean age of intervention group (received intervention) = 80.9 Mean age of comparison group = 81.3.</li> <li>• Sex - Intervention group (randomised) = 20 males / 52 females Intervention group (received intervention) = 14 males / 50 females Comparison group = 27 males / 43 females.</li> <li>• Ethnicity – Not reported.</li> <li>• Religion/belief – Not reported.</li> <li>• Disability – Not reported.</li> </ul>	<p><b>Statistical data – service outcomes –</b></p> <p>Number of admissions: There was no significant difference in number of admissions for both groups (intervention = 46 vs. comparison = 51). Average hospital stay was the same in both groups (12.6 days; mean difference 9.2-16.1 [95% Confidence Interval] for the intervention group and 7.4-17.8 [95% Confidence Interval] for the comparison group).</p> <p>Use of nursing home or home care: There were no significant differences in need for nursing homes and home care after 12 months, with both 32 (54.2%) from the intervention and 32 (66.7%) from the comparison group still needing long-term home nurse care.</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Long term health condition - The most common primary diagnosis was cardiological diseases: Intervention group (randomised) = 22 Intervention group (received intervention) = 21 Comparison group = 20. Other reported conditions included infections, fractures/contusions, pulmonary diseases, neurological diseases, cancers, psychiatric diseases and other diseases.</li> <li>• Sexual orientation – Not reported.</li> <li>• Socioeconomic position – Not reported.</li> </ul> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers - n=70. Intervention numbers – randomised n=72, received intervention n=64.</li> <li>• Sample size – Total n=142.</li> </ul>	<p>Slightly more participants in the intervention group (n=10; 28.8%) were independent of home care, in comparison to the general hospital group (n=7; 18.8%).</p> <p>Mortality: The difference in number of deaths between groups was statistically significant.</p> <p>Participants in the intervention group were observed for a longer period of time than those in the comparison group (335.7 [95% Confidence Interval 312.0-359.4] v 292.8 [95% confidence interval 264.1-321.5]) days (p=0.01).</p> <p><b>Narrative findings – service outcomes -</b> Participants who received intermediate care had better outcomes than those receiving standard care, with</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Bed-based intermediate care.</li> <li>• Describe intervention - The intervention was based on individualised intermediate care, focussing on improving physical functioning so that participants would be able to manage independently on returning home.</li> <li>• Delivered by - The intervention was delivered by the multi-disciplinary team.</li> <li>• Delivered to - The intervention was delivered to service users who had been admitted to hospital due to acute illness/exacerbation of chronic disease and were subsequently randomised to the intermediate care condition.</li> <li>• Duration, frequency, intensity, etc. - This is not reported.</li> </ul>	<p>fewer needing community services, and significantly fewer being dead after 12 months.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Key components and objectives of intervention - The main objective of the intervention was to improve physical functioning so that participants would be able to manage independently on returning home.</li> <li>• Content/session titles – N/A.</li> <li>• Location/place of delivery - The intervention took place at a community hospital.</li> </ul> <p><b>Comparison intervention:</b> The comparison intervention was standard prolonged care at a general hospital, where normal routines were followed. No further information is provided.</p> <p><b>Outcomes measured:</b> Service user related outcomes</p> <ul style="list-style-type: none"> <li>• Mortality.</li> </ul> <p>Service outcomes –</p> <ul style="list-style-type: none"> <li>• Number of days in institution, readmissions were assessed</li> </ul>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>through patients' journals and health records, as well as administrative systems.</p> <p><b>Follow-up:</b> 6 and 12 months after baseline.</p> <p><b>Costs?</b> No.</p>		

**4. Herfjord JK, Heggstad T, Erslund H et al. (2014) Intermediate care in nursing home after hospital admission: a randomized controlled trial with one year follow-up. BMC Research Notes 7: 889**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> To evaluate the efficacy and safety of early transfer to an intermediate care unit in a nursing home.</p> <p><b>Methodology:</b> Randomised controlled trial. Participants randomised to either an intermediate care unit in a nursing home or usual care in the hospital.</p> <p><b>Country:</b> Norway – Bergen.</p> <p><b>Source of funding:</b></p>	<p><b>Participants:</b> Service users and their families, partners and carers - Individuals over the age of 70 admitted to a medical or orthopaedic ward from their home. Staff at the 2 hospitals from which participants were recruited were '... requested to consider every patient 70 year [sic] or older admitted from home' (p5). Individuals were eligible if they were respiratory and circulatory stable, and viewed as being able to return to their</p>	<p><b>Statistical data – service user related outcomes -</b></p> <p>Days alive (mean number): All patients – Not reported. Medical patients – Not reported.</p> <p>Orthopaedic patients – The mean number of days alive was significantly lower for orthopaedic patients in the intervention group than for orthopaedic patients in the control group (control 346.9 vs. intervention 311.9, 35 days lower; p=0.025).</p>	<p><b>Overall assessment of internal validity:</b></p> <p>+</p> <p>Although the study appears to have been well carried out the decision to change the outcomes measured for the second phase of the study, the fact that a small number of participants allocated to the intervention had to remain in acute care, and the post hoc decision to conduct subgroup analysis means</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<ul style="list-style-type: none"> <li>Government - Western Norway Regional Health Authority.</li> <li>Other - Kavli Research Centre for Geriatrics and Dementia.</li> </ul>	<p>home within 3 weeks. Exclusion criteria were – need for intensive care or surgery, and severe dementia or delirium. The authors note that patients with mild or moderate dementia were eligible.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>Age - Mean (range) –</li> <li>Control - All patients = 84.6 (71-98); medical patients = 85.2 (72-98); orthopaedic patients = 83.9 (71-95).</li> <li>Intervention - All patients = 83.6 (70-96); medical patients = 83.9 (70-96); orthopaedic patients = 84.0 (70-95).</li> <li>Sex – Proportion of females -</li> <li>Control - All patients = 73.7%; medical patients = 61.1%; orthopaedic patients = 82.4%.</li> <li>Intervention - All patients = 73.2%; medical patients =</li> </ul>	<p>Days alive and living at home (mean number):</p> <p>All patients – The mean number of days alive and living at home was lower in the intervention group than the control group, however this difference was not significant; control 256.5 days (125.1 SD) vs. intervention 253.7 days (120.4 SD), relative effect size ÷ 1.1%, absolute effect size ÷ 2.8 days, p=0.80.</p> <p>Medical patients – The mean number of days alive and living at home was lower for medical patients in the intervention group than those in the control group, however this difference was not significant; control 250.4 days (134.1 SD) vs. intervention 249.2 days (123.6 SD), relative effect size ÷ 0.5%, absolute effect size ÷ 1.2 days, p=0.165.</p> <p>Orthopaedic patients – The mean number of days alive</p>	<p>that it is not possible to award a higher quality rating to this study.</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall assessment of validity:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>61.5%; orthopaedic patients = 85.0%.</p> <ul style="list-style-type: none"> <li>• Ethnicity – Not reported.</li> <li>• Religion/belief - Not reported.</li> <li>• Disability - Not reported.</li> <li>• Long term health condition - Not reported.</li> <li>• Socioeconomic position - Not reported.</li> </ul> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers – n=200 randomised; n=186 received control intervention (14 participants withdrew consent after randomisation).</li> <li>• Intervention numbers – n=200 randomised; n=190 received intervention (10 participants withdrew consent after randomisation; 8 did not receive the intervention due to medical concerns and remained in acute care).</li> </ul>	<p>and living at home was lower for orthopaedic patients in the intervention group than those in the control group, however this difference was not significant; control 256.5 days (121.0 SD) vs. intervention 233.2 days (128.2), relative effect size ÷ 9.1%, absolute effect size ÷ 23.3 days, p=0.09.</p> <p>One year mortality: All patients – Mortality was higher in the intervention group than in the control group, however this difference was not significant (control 17.2% vs. intervention 22.1%, relative effect size + 28.5%; absolute effect size + 4.9%, p=0.29). The relative risk of mortality was also higher for this group; relative risk 1.29 (95% CI 0.85 to 1.94). Medical patients – Mortality was higher in the intervention group than in the control</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Sample size – N=400; n=368 received intended interventions.</li> </ul> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Bed based intermediate care.</li> <li>• Describe intervention - The authors describe intermediate care as a ‘step-down’ facility.</li> <li>• Delivered by - The units were staffed by a multidisciplinary team including a health care worker, physician, physiotherapist, and nurse. The physician was either a consultant specialist in geriatrics/internal medicine or a junior doctor working under the supervision of the consultant specialist; however this post only appears to have been staffed on weekdays. The number of full-time nursing positions increased from 3 to 12.7 after the unit was</li> </ul>	<p>group, however this difference was not significant (control 25.0% vs. intervention 25.6%, relative effect size + 2.4%, absolute effect size + 0.6%, p=0.99. The relative risk of mortality was also higher for this group; relative risk 1.03 (95% CI 0.59-1.78).</p> <p>Orthopaedic patients – Mortality was significantly higher in the intervention group than in the control group (control 10.3 % vs. intervention 25.0%, relative effect size + 142.7%, absolute effect size 14.7%, p=0.049). The relative risk of mortality was also higher for this group; relative risk 2.43 (95% CI 1.05 to 5.55).</p> <p><b>Statistical data – service outcomes -</b> Days in hospital after discharge from control/intervention (mean number):</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>converted into an intermediate care unit.</p> <ul style="list-style-type: none"> <li>• Delivered to - Individuals over the age of 70 admitted to a medical or orthopaedic ward from their home.</li> <li>• Duration, frequency, intensity, etc. - Maximum stay was specified as 3 weeks. The average length of stay at the facility was 17.3 days (range 1-34). Further details on intensity of care/therapies is not clear, however the patient was assessed by a physician and physiotherapist on the first working day after their admission, and physician led ward rounds and multidisciplinary team meetings took place at least twice a week.</li> <li>• Key components and objectives of intervention - A key aspect of the service which the researchers hoped to investigate was earlier transfer to the unit (noting</li> </ul>	<p>All patients - The mean number of days in hospital was lower for participants in the intervention group than those in the control group, however this difference was not significant (control 10.5 days, 15.2 SD vs. intervention 10.4 days, 15.8 SD; relative effect size ÷ 0.01%; absolute effect size ÷ 0.1 days; p=0.748).</p> <p>Medical patients – The mean number of days in hospital was lower for medical patients in the intervention group than those in the control group, however this difference was not significant; control 12.9 days (17.2 SD) vs. intervention 10.6 days (14.9 SD); relative effect size ÷ 18.1%; absolute effect size ÷ 2.3 days; p=0.530.</p> <p>Orthopaedic patients – The mean number of days in hospital was greater for orthopaedic patients in the intervention group than those</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>that patients in earlier studies were usually transferred after a number of days in hospital). Transfer took place within 1 working day of randomisation (mean 0.7 days, range 0–three). Patients were also assessed using a ‘comprehensive geriatric assessment’ (Ellis and Langhorne, 2005). Patients were encouraged to mobilise and get out of their bed as soon as possible; to exercise (individual physiotherapy, group exercise classes and mobility aids were provided). Nutrition and the environment at meal times were considered, information about the patients home environment and presence of a carer was gathered and staff made referrals to occupational or speech therapy where necessary and helped patients to apply for further home health care</p>	<p>in the control group, however this difference was not significant control 8.2 days (12.7 SD) vs. intervention 12.0 days (19.0 SD); relative effect size + 46.6%; absolute effect size + 3.8 days; p=0.536.</p> <p>Days in nursing home (mean number): All patients – The mean number of days in a nursing home was significantly lower for participants in the intervention group than those in the control group; control 55.0 days (91.7 SD) vs. intervention 40.6 days (71.4 SD); relative effect size ÷ 26.1%; absolute effect size ÷ 14.4 days; p=0.046. Medical patients - The mean number of days in a nursing home was lower for medical patients in the intervention group than those in the control group, however this difference was not significant;</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>services or residential care if needed. Multidisciplinary team meetings considered arrangements for care after discharge from the unit.</p> <ul style="list-style-type: none"> <li>• Location/place of delivery - Fifteen bed intermediate care unit in a nursing home. Although the unit could not provide intensive care it did have facilities to analyse some blood tests on site as well as equipment for bladder scans, ECGs, intravenous treatment, oxygen supply, pulse oximetry, and a nebuliser for inhalation.</li> </ul> <p><b>Comparison intervention:</b> Hospital based care as usual according to condition. The authors note that what this entailed could vary between the 2 hospital sites at which participants randomised to the control group received their care, and even between different departments within</p>	<p>control 44.1 days (86.5 SD) vs. intervention 37.8 days (62.9 SD) relative effect size ÷ 14.3%; absolute effect size ÷ 6.3 days; p=0.876.</p> <p>Orthopaedic patients - The mean number of days in a nursing home was lower for orthopaedic patients in the intervention group than those in the control group, however this difference was not significant; control 74.7 days (106.0 SD) vs. intervention 49.5 days (0.192 SD); relative effect size ÷ 33.7%; absolute effect size ÷ 25.2 days; p=0.192.</p> <p>Days without home health care (mean number): All patients – The mean number of days without home health care services was significantly longer for participants in the intervention group than those in the control group; control 97.7 days vs. intervention</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>the same hospital. They suggest that key differences between care as usual in the hospital and that provided in the intermediate care unit were – facilities for diagnostic tests, monitoring equipment (e.g. telemetry), and the availability of a physician at weekends. It is noted that multidisciplinary assessments and consultation by a geriatrician were unlikely to be carried out as standard. The mean length of stay in the comparison intervention 7.0 days (range 0–36).</p> <p><b>Outcomes measured:</b> NB All outcomes data were extracted from patient records held with hospitals or community health care services. The following data were extracted by the researchers -</p> <p>Service user related outcomes</p> <ul style="list-style-type: none"> <li>• Days alive and living at home.</li> <li>• Mean number of days alive.</li> </ul>	<p>70.2 days; 27.5 days longer; p=0.027.</p> <p>Medical patients - The mean number of days without home health care services was significantly longer for medical patients in the intervention group than those in the control group; control 97.2 days vs. intervention 53.5 days; 52.0 days longer (97.2 vs. 53.5); p=0.01.</p> <p>Orthopaedic patients: Subgroup analysis not reported.</p> <p>Independence from home health care:</p> <p>All patients – The proportion of participants in the intervention group who were ‘independent’ of home health care services was significantly higher than that in the control group; (control 19.9% vs. intervention 31.6%, relative effect size +58.8%, absolute effect size +11.7%, p=0.007). The relative risk of</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• One year mortality.</li> </ul> <p>Service outcomes –</p> <ul style="list-style-type: none"> <li>• Days in a nursing home.</li> <li>• Days in hospital.</li> <li>• ‘Independence’ from home health care, and mean number of days without home health care.</li> <li>• No home health care. The authors defined home health care services as publicly funded supportive care provided in the home. Supportive care is described as ‘... help provided by licensed healthcare professionals, non-medical caregivers or care assistants for medical needs, help in activities of daily living and help for practical needs like cleaning the home and preparing meals’ (p4).</li> </ul> <p>Patient classification details (medical or orthopaedic) were extracted from hospital</p>	<p>being ‘independent’ from home health care services was also higher for this group; relative risk 1.59 (95% CI 1.11 to 2.27).</p> <p>Medical patients – The proportion of medical patients who were ‘independent’ of home health care services in the intervention group was significantly higher than that in the control group (control 18.1% vs. intervention 35.9%, relative effect size +98.6%, absolute effect size +17.8%, p=0.011). The relative risk of being ‘independent’ from home health care services was also higher for this group; relative risk 1.99 (95% CI 1.12 to 3.53).</p> <p>Orthopaedic patients – The proportion of orthopaedic patients who were ‘independent’ of home health care services in the intervention group was higher than that in the control group, however this difference was</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>discharge notes, which the authors report use ICD-10 definitions as the basis for classification.</p> <p><b>Follow-up:</b> 1 year post-randomisation.</p>	<p>not significant (control 19.1% vs. intervention 30.0%, relative effect size +57.1%, absolute effect size +10.9%, p=0.219). The relative risk of being 'independent' from home health care services was also higher for this group; relative risk 1.57 (95% CI 0.84 to 2.93).</p> <p><b>Narrative findings - service user related outcomes</b> NB. Although the authors calculate 'relative effect sizes' these are not included in this summary.</p> <p>At 1 year post-randomisation, mortality was higher in the intervention group than in the control group, however this difference was not significant (control 17.2% vs. intervention 22.1%; absolute effect size + 4.9%; p=0.29). Post hoc subgroup analysis showed that mortality was also higher for medical</p>	

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		<p>patients in the intervention group, however this was also non-significant (control 25.0% vs. intervention 25.6%; absolute effect size + 0.6%; p=0.99). However, mortality was significantly higher for orthopaedic patients in the intervention group (control 10.3 % vs. intervention 25.0%; absolute effect size 14.7%; p=0.049). Similarly, there was a non-significant increased relative risk of mortality for participants in the intervention group (relative risk ratio = 1.29, 95% CI 0.85 to 1.94), and for medical patients in the intervention group (relative risk ratio = 1.03, 95% CI 0.59 to 1.78). However, relative risk for orthopaedic patients in the intervention group was significantly increased (relative risk ratio = 2.43, 95% CI 1.05 to 5.55). The mean number of days alive was significantly lower for</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>orthopaedic patients in the intervention group than for orthopaedic patients in the control group (control 346.9 vs. intervention 311.9; 35 days lower; p=0.025). Data in relation to mean number of days alive for all patients or for medical patients are not reported.</p> <p><b>Narrative findings - service outcomes –</b>  The mean number of days alive and living at home over the 1 year follow-up period was lower in the intervention group than the control group, however this difference was not significant (control 256.5 days [125.1 SD] vs. intervention 253.7 days [120.4 SD]; absolute effect size ÷ 2.8 days; p=0.80). This was also the case for medical patients in the intervention group (control 250.4 days [134.1 SD] vs. intervention 249.2 days [123.6 SD];</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>absolute effect size ÷ 1.2 days; p=0.165); and for orthopaedic patients in the intervention group (control 256.5 days [121.0 SD] vs. intervention 233.2 days [128.2 SD]; absolute effect size ÷ 23.3 days; p=0.09).</p> <p>The mean number of days in hospital (after discharge from the intervention/control treatment) was lower for participants in the intervention group than those in the control group, however this difference was not significant (control 10.5 days [15.2 SD] vs. intervention 10.4 days [15.8 SD]; absolute effect size ÷ 0.1 days; p=0.748). This was also the case for medical patients in the intervention group (control 12.9 days [17.2 SD] vs. intervention 10.6 days [14.9 SD]; absolute effect size ÷ 2.3 days; p=0.530). For orthopaedic patients in the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>intervention group, the mean number of days in hospital was higher than that in the control group, however this difference was also non-significant (control 8.2 days [12.7 SD] vs. intervention 12.0 days [19.0 SD]; absolute effect size + 3.8 days; p=0.536).</p> <p>The mean number of days in a nursing home was significantly lower for participants in the intervention group than those in the control group (control 55.0 days [91.7 SD] vs. intervention 40.6 days [71.4 SD]; absolute effect size ÷ 14.4 days; p=0.046). The mean number of days in a nursing home was also lower for medical patients in the intervention group (control 44.1 days [86.5 SD] vs. intervention 37.8 days [62.9 SD]; absolute effect size ÷ 6.3 days; p=0.876); and</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>orthopaedic patients in the intervention group (control 74.7 days [106.0 SD] vs. intervention 49.5 days [0.192 SD]; absolute effect size <math>\pm</math> 25.2 days; <math>p=0.192</math>), however these differences were non-significant.</p> <p>The mean number of days without home health care services was significantly greater for participants in the intervention group than those in the control group (control 70.2 days vs. intervention 97.7 days; 27.5 days longer; <math>p=0.027</math>). This was also the case for medical patients in the intervention group (control 53.5 days vs. intervention 97.2 days; 52.0 days longer; <math>p=0.01</math>). Data in relation to mean number of days without home health care services for orthopaedic patients are not reported.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>The proportion of participants in the intervention group who were 'independent' of home health care services was significantly higher than that in the control group (control 19.9% vs. intervention 31.6%; absolute effect size +11.7%; <math>p=0.007</math>). This was also the case for medical patients in the intervention group (control 18.1% vs. intervention 35.9%; absolute effect size +17.8%; <math>p=0.011</math>).</p> <p>The proportion of orthopaedic patients who were 'independent' of home health care services in the intervention group was also higher than that in the control group, however this difference was not significant (control 19.1% vs. intervention 30.0%; absolute effect size +10.9%, <math>p=0.219</math>).</p> <p>Similarly, there was a significantly increased relative risk of independence from home health care</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		services for participants in the intervention group (relative risk = 1.59, 95% CI 1.11 to 2.27); and for medical patients in the intervention group (relative risk = 1.99, 95% CI 1.12 to 3.53). For orthopaedic patients in the intervention group there was a non-significant increased relative risk (relative risk = 1.57, 95% CI 0.84 to 2.93).	

**5. Kalra L, Evans A, Perez I et al. (2005) A randomised controlled comparison of alternative strategies in stroke care. Health Technology Assessment 9: 18**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<b>Study aim:</b> To compare a range of outcomes at 3, 6 and 12 months between stroke patients managed on the stroke unit (SU), on general wards with stroke team (ST) support or at home by specialist domiciliary care team (HC).	<p><b>Participants:</b> Service users and their families, partners and carers - patients with disabling stroke.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>Age - Median age - stroke unit 75 years; stroke team support 77.3 years; home care 77.7 years.</li> </ul>	<b>Statistical data – service user related outcomes -</b> Mortality or institutionalised at 3 months: Participants managed in the stroke unit were significantly less likely to die or be institutionalised compared with home care group (stroke unit 10% vs. home care 20%, relative risk = 0.50, [95% Confidence	<p><b>Overall assessment of internal validity:</b> ++</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> ++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Methodology:</b> Prospective, single-blind, randomised controlled trial.</p> <p><b>Country:</b> UK – south east England – Bromley.</p> <p><b>Source of funding:</b> Government - Health Technology Assessment Programme.</p>	<ul style="list-style-type: none"> <li>• Sex - females - stroke unit 46.6, stroke team support 50.6, home care 45.6%.</li> <li>• Ethnicity - not reported.</li> <li>• Religion/belief - not reported.</li> <li>• Disability – Number of patients with premorbid independence in continence (stroke unit n=146; stroke team support n=147; home care n=148), dressing (stroke unit n=146; stroke team support n=143; home care n=142), mobility (stroke unit n=145; stroke team support n=146; home care: n=146).</li> <li>• Long term health condition – Risk factor profile - Previous stroke/transient ischaemic attack - stroke unit 26%; stroke team 29%; home care 30%. Hypertension - stroke unit: 45%; stroke team 48%; home care 48%. Diabetes mellitus - stroke unit: 11%; stroke team 16%; home care 15%. Atrial fibrillation -</li> </ul>	<p>Interval 0.29 to 0.87], p=0.01). There was no significant difference in mortality or institutionalisation rate between the stroke team and home care groups (stroke team 20% vs. home care 20%, relative risk = 1.00, [95% CI 0.96 to 1.04], p=0.99).</p> <p>Mortality or institutionalised at 6 months: Participants managed in the stroke unit were significantly less likely to die or be institutionalised compared with the home care group (stroke unit 13% vs. home care 24%, relative risk = 0.42 [95% CI 0.24 to 0.75], p=0.003). There was no significant difference in mortality or institutionalisation rate between the stroke team and the home care group (stroke team 25% vs. home care 24%, relative risk = 1.05 [95% CI 0.71 to 1.56], p=0.81).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>stroke unit 24%; stroke team 27%; home care 16%. Smoking - stroke unit: 19%; stroke team 14%; home care 15%. Ischaemic heart disease - stroke unit: 22%; stroke team 25%; home care 21%. Carotid bruit - stroke unit 3%; stroke team 5%; home care 3%. Median Orgogozo score - stroke unit 75 (46–90 IQR); stroke team 80 (60–90 IQR); home care 85 (58–90 IQR). Median OPS score (1.6–6.8) - stroke unit 3.2 (2.4–4.4 IQR); stroke team 3.2 (2.4–4.4 IQR); home care 2.8 (2.0–4.0 IQR). Median Barthel Index score - stroke unit 8 (5–12 IQR); stroke team 9 (5–12 IQR); home care 10 (4–14 IQR).</p> <ul style="list-style-type: none"> <li>• Sexual orientation - Not reported.</li> <li>• Socioeconomic position - Lives alone - stroke unit 33.7%; stroke team 36.6% home care 33.5%.</li> </ul>	<p>Mortality or institutionalised at 12 months: Patients managed in the stroke unit were significantly less likely to die or be institutionalised compared with the home care group (stroke unit 14% vs. 24%, relative risk = 0.59 [95% CI 0.37 to 0.95], p=0.03. There was no significant difference in mortality or institutionalisation rate between the stroke team and the home care group (stroke team 30% vs. home care 23%, relative risk = 1.28 [95% CI 0.87 to 1.87], p=0.20. After adjusting for age, baseline Barthel Index scores and dysphasia at all time-points, the odds of dying or being institutionalised at 1 year were 3.2 greater for stroke team patients and 1.8 greater for patients receiving specialist home care when compared with stroke unit care. (Cox's regression</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers - domiciliary care (n=153).</li> <li>• Intervention numbers - 152 stroke unit care (n=152), stroke team care (n=152).</li> <li>• Sample size – Total N=457.</li> </ul> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Stroke care managed on the stroke unit vs on general wards with stroke team support vs at home by specialist domiciliary team. Describe intervention - Two interventions: 1. Stroke team (ST): Patients in the stroke team care were managed on general wards and remained under the care of admitting physicians. All patients were seen by a specialist team, which consisted of a doctor (specialist registrar grade), a nurse (grade G), a physiotherapist (senior I) and an occupational therapist</li> </ul>	<p>survival analysis – stroke team 43 events vs. stroke unit 18 events; odds ratio = 3.2 [95% CI 1.6 to 6.4], p=0.001; hazards ratio = 2.4 [95% CI 1.4 to 4.2], p=0.002, stroke unit 18 events vs. home care 30 events; odds ratio = 1.8 [95% CI 1.0 to 3.8], p=0.03), Hazards ratio (HR) 1.7 (95% CI 1.0 to 3.0), p=0.04 (significant).</p> <p>Mortality rate at 3 months: There was a significantly lower mortality rate in the stroke unit group than the home care group (stroke unit 4% vs home care 10%, relative risk = 0.41 [95% CI 0.17 to 0.98], p=0.05. There was no significant difference in mortality rates between the stroke team and the home care group (stroke team 12% vs. home care 10%, relative risk = 1.24 [95% 0.64 to 2.38], p=0.52).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>(senior I) with expertise in stroke management. Patients were assessed and evaluated for medical, nursing and therapy needs, based on a plan for investigations and acute management guided by standardised guidelines. Although generic staff on the ward provided the day-to-day treatment, the team advised reviewed progress and treatment goals of individual patients with the ward team and helped in discharge planning and setting up of post-discharge services. The team also provided counselling, education and support to the family, identified expectations and advised about realistic outcomes in the context of previous morbidity and present deficits. 2. Stroke Unit (SU): patients in this group received care on the stroke</p>	<p>Mortality rate at 6 months: There was no significant difference in mortality rate between the stroke unit and the home care group (stroke unit 7% vs. home care 13%, relative risk = 0.50 [95% 0.25 to 1.02] p=0.06). There was no significant difference in mortality rates between the stroke team and the home care group (stroke team 17% vs. home care 13%, relative risk = 1.27 [95% CI 0.74 to 2.19] p=0.39).</p> <p>Mortality rate at 1 year: There was no significant difference in mortality rate between the stroke unit and the home care group (stroke unit 9% vs. home care 15%, relative risk = 0.59 [95% CI 0.31 to 1.11] p=0.10). There was no significant difference in mortality rate between the stroke team and the home care group (stroke team 23% vs. home care 15%, relative</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>unit (acute and rehabilitation) was provided by a stroke physician supported by a multidisciplinary team with specialist experience in stroke management. There were clear guidelines for acute care, prevention of complications, rehabilitation and secondary prevention, and a culture of joint assessments, goal setting, coordinated treatment and discharge planning. A coordinated multidisciplinary approach was adopted towards rehabilitation, with emphasis on early mobilisation. All patients had an individualised rehabilitation plan with clearly defined goals based on joint assessments. Patient participation was encouraged, with focus on motivation and providing an enriched environment. A plan of management, individualised to each</p>	<p>risk = 1.56 [95% CI 0.96 to 2.53] p=0.07).</p> <p>Barthel Index scores at 3 months: There was no significant difference between the 3 groups (stroke unit 82% vs. home care 73%, relative risk = 1.11 [95% CI 0.99 to 1.25] p=0.09; stroke team 70% vs. home care 73%, relative risk = 0.96 [95% CI 0.83 to 1.11] p=0.58.</p> <p>Dependence (modified Rankin Scale, survival without severe disability) at 1 year: Significantly more participants survived without severe disability in the stroke unit group compared with the home care group (stroke unit 85% vs. home care 71%, relative risk = 1.21 [95% CI 1.07 to 1.37], p=0.002). There was no significant differences between the stroke team and the home care group (stroke team 66% vs. home care</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>patient's needs, was formulated and communicated to the various professionals involved in the patient's care, the patient and the family. All patients were screened and managed for stroke risk factors and secondary prevention. There was close liaison between various disciplines, with problems being addressed as they arose. Discharges were planned in advance, and spouses and relatives were encouraged to participate in the rehabilitation process.</p> <ul style="list-style-type: none"> <li>Delivered by - Stroke team (ST) in hospital: delivered by a specialist team, which consisted of a doctor (specialist registrar grade), a nurse (grade G), a physiotherapist (senior I) and an occupational therapist (senior I) with expertise in stroke management. Stroke unit (SU) in hospital: (acute</li> </ul>	<p>71%, relative risk = 0.94 [95% CI 0.81 to 1.09] p=0.42).</p> <p>Changes in Barthel Index scores at 6 months and 1 year for survivors (stroke unit n=138; stroke team n=115; home care n=123) - baseline comparisons similar for age, gender and premorbid functional abilities: Survivors in the stroke unit group showed a significantly greater change than those in the home care group at 6 months (stroke unit 9 vs home care 7, p&lt;0.02) and at 1 year (stroke unit 10 vs. home care 7, p&lt;0.002).</p> <p>Changes in FAI scores for survivors (stroke unit n=138; stroke team n=115; home care n=123) - baseline comparisons similar for age, gender and premorbid functional abilities: Differences between pre-stroke and post-stroke</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>and rehabilitation) care provided by a stroke physician supported by a multidisciplinary team with specialist experience in stroke management.</p> <ul style="list-style-type: none"> <li>• Delivered to - Stroke patients.</li> <li>• Duration, frequency, intensity, etc. - No report of duration, frequency and intensity of intervention. Outcomes were assessed at 3, 6 and 12 months.</li> <li>• Key components and objectives of intervention - See 'describe intervention'.</li> <li>• Content/session titles – N/A.</li> <li>• Location/place of delivery - Stroke team and stroke unit in hospital (bed-based).</li> </ul> <p><b>Comparison intervention:</b> Home (domiciliary) care - Patients in the home care group were managed in their own home by a specialist team consisting of a doctor</p>	<p>function were greatest in the stroke unit group and least in the home care group (p&lt;0.005 at 6 months; p&lt;0.01 at 1 year).</p> <p>Hospital Anxiety and Depression Scale scores – Anxiety: There were no significant differences between the 3 groups at 3 months (stroke unit 3 vs. stroke team 4 vs. home care 3, non-significant) or at 1 year (stroke unit 2 vs. stroke team 2 vs. home care 2, non-significant).</p> <p>Hospital Anxiety and Depression Scale scores – Depression: There were no significant differences between the 3 groups at 3 months (stroke unit 3 vs. stroke team 3 vs. home care 3, non-significant), or at 1 year (stroke unit 2.5 vs. stroke team 3 vs. home care 2, non-significant).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>(specialist registrar), a nurse (G grade) and therapists (senior I grades), with support from district nursing and social services for nursing and personal care needs. Patients were under the joint care of the stroke physician and GP, who retained the clinical responsibility for patients managed in the community, supported by the stroke team. The stroke team consisted of the stroke nurse (coordinator), doctor, physiotherapist and occupational therapist, and will be supported by the district nurses and social services care managers. They liaised closely with the GP and the stroke consultant to maintain continuity of care, provided timely information on progress and were responsive to general practice concerns and comments. Investigations, including CT scanning, were performed on an outpatient basis. Therapy was provided</p>	<p>EuroQol analogue scores: Significant higher rating in the stroke unit and home care groups compared with the stroke team group at 3 months (stroke unit 75 vs. stroke team 60 vs. home care 73; home care vs. stroke team, <math>p &lt; 0.005</math>). There was no significant difference between the 3 groups at 1 year (stroke unit 80 vs. stroke team 75 vs. home care 75, non-significant).</p> <p><b>Statistical data – satisfaction with services</b>  Patient satisfaction at 3 months: Patients in the home care group were more satisfied with the care provided by the domiciliary stroke team compared with the stroke unit or stroke team. This was significant for 'being able to talk about problems with professionals' (Chi-sq 25.5, <math>p &lt; 0.0001</math>), 'information on the nature and cause of</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>by members of the specialist stroke team. Each patient had an individualised integrated care pathway outlining activities and the objectives of treatment, which was reviewed at weekly multidisciplinary meetings. This support was provided for a maximum of 3 months. Patients' progress were monitored on a regular basis in multidisciplinary meetings. The team reviewed patients on the basis of comprehensive assessments, goals and progress. Problems in rehabilitation of individual patients were discussed at these meetings. Patient/carer involvement was encouraged as appropriate. Specialist support was provided from the hospital to support the 'shared care' with general practitioners.</p> <p><b>Outcomes measured:</b></p> <p>Service user related outcomes</p> <p>-</p>	<p>the stroke' (Chi-sq 8.6, p&lt;0.014)' 'organisation of care at home' (Chi-sq 11.6, p&lt;0.003), 'support from community services' (Chi-sq 13.2, p&lt;0.001), 'the amount of contact with the specialist team' (Chi-sq 99.4, p=0.009).</p> <p>Carer satisfaction: Carers rated care provided at home (home care group) to be more satisfactory than that provided on the stroke unit or stroke team. This was significant for ' attention to personal needs of the patient' (Chi-sq = 13.1, p=0.001), 'recognition of problems associated with caring for stroke patients' (Chi-sq 22.1, p&lt;0.0001), 'amount of therapy provided (Chi-sq 13.8, p=0.001), information on benefits and services (Chi-sq 10.6, p=0.005) 'the level of contact with the specialist team' (Chi-sq 23.8, p&lt;0.0001).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Death or institutionalisation at 1 year.</li> <li>• Dependence (measured using modified Rankin Scale - death is rated as 6), and the Barthel Index (scores of 15–20 classified as favourable).</li> <li>• Disability (measured using Barthel Index and Frenchay Activities Index).</li> <li>• Extent and severity of neurological deficit (measured using the Orgogozo scale).</li> <li>• Mood (measured using Hospital Anxiety and Depression Scale).</li> <li>• Quality of life (measured using EuroQol).</li> </ul> <p>Family or caregiver related outcomes –</p> <ul style="list-style-type: none"> <li>• Quality of life (EuroQol).</li> </ul> <p>Satisfaction with services –</p> <ul style="list-style-type: none"> <li>• Satisfaction with care and professional acceptability.</li> </ul>	<p>Professional acceptability of domiciliary care (general practitioners, district nurses and social services care managers): Sample too small to allow meaningful statistical analysis.</p> <p><b>Statistical data – service related outcomes</b></p> <p>Lengths of hospital stay (mean number of days): stroke unit 32 (29.6 SD) vs. stroke team 29.5 (40.1 SD) vs home care 48.9 (26.6 SD) for 51 patients requiring hospital admission from home.</p> <p>Physiotherapy (% of patients treated): Similar between the 3 groups – stroke unit 99% vs. stroke team 97% vs. home care 99%.</p> <p>Occupational therapy (% of patients treated): Similar between the 3 groups - stroke</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>Service outcomes -</p> <ul style="list-style-type: none"> <li>• Length of hospital stay.</li> </ul> <p><b>Follow-up:</b> At 3, 6 and 12 months.</p> <p><b>Costs?</b> Cost information. See economic evidence tables.</p>	<p>unit 100% vs. stroke team 87% vs. home care 99%.</p> <p>Speech therapy (% of patients treated): Higher use in the stroke unit group than the home care group – stroke unit 71% vs. stroke team 47% vs. home care 49%. Patients on the stroke unit received significantly more therapy compared with those managed by the stroke team or at home. There were no significant differences in the duration of therapy between the stroke team and the home care group.</p>	

**6. Stenvall M, Olofsson B, Nyberg L et al. (2007) Improved performance in activities of daily living and mobility after a multidisciplinary postoperative rehabilitation in older people with femoral neck fracture: A randomized controlled trial with 1-year follow-up. Journal of Rehabilitation Medicine 39: 232-8**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<b>Study aim:</b> The aim of the study was to investigate the short and long-term effects of a multidisciplinary postoperative	<b>Participants:</b> Service users and their families, partners and carers - Participants were service users.	<b>Statistical data – service user related outcomes -</b> Living independently: Intervention group	<b>Overall assessment of internal validity:</b> +

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>rehabilitation programme in patients with femoral neck fracture.</p> <p><b>Methodology:</b> Randomised controlled trial. Stratified according to the operation methods used based on the degree of hip dislocation.</p> <p><b>Country:</b> Sweden.</p> <p><b>Source of funding:</b> Other - Swedish Research Council.</p>	<p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Mean age of intervention group = 82.3 Mean age of comparison group = 82.</li> <li>• Sex - Intervention group = 74 females Comparison group = 74 females.</li> <li>• Ethnicity – Not reported.</li> <li>• Religion/belief – Not reported.</li> <li>• Disability - Sensory impairments are reported: Impaired hearing Intervention group = 42 Comparison group = 34 Impaired vision Intervention group = 37 Comparison group = 27. No significant difference between the 2 groups.</li> <li>• Long term health condition - Health and medical problems are reported; the most common being cardiovascular disease, depression, stroke, and</li> </ul>	<p>significantly more likely than control group to live independently – at discharge (odds ratio = 0.93 [95% Confidence Interval 0.32 to 2.73]); at 4 months (odds ratio = 0.68 [95% CI 0.20 to 2.27]); and at 12 months (odds ratio = 0.91 [95% CI 0.32 to 2.56] at 12 months.</p> <p>Independent walking without walking aid indoors: Intervention group significantly more likely than control group to walk without walking aid (adjusted for dementia and depression) at discharge (odds ratio = 2.22 [95% CI 0.99 to 4.95]); at 4 months (odds ratio = 3.01 [95% CI 1.18 to 7.61]); and at 12 months.</p> <p>Independent P-ADL: Intervention group significantly more likely than control group to regain P-ADL (adjusted for dementia and</p>	<p><b>Overall assessment of external validity:</b> +</p> <p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>dementia. Other reported conditions include cancer, previous hip fracture and diabetes. No significant difference between the 2 groups. Significantly more 'diagnosed depression' (intervention 33, control 45, <math>p=0.031</math>) and 'antidepressants' use (intervention 29, control 45, <math>p=0.009</math>) in the control group.</p> <ul style="list-style-type: none"> <li>• Sexual orientation – Not reported.</li> <li>• Socioeconomic position – Not reported.</li> </ul> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers - <math>n=97</math>.</li> <li>• Intervention numbers - <math>n=102</math>.</li> <li>• Sample size - Total <math>N=199</math>.</li> </ul> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Bed-based intermediate care (a</li> </ul>	<p>depression) at discharge (odds ratio 1.81 [95%CI 0.74–4.37]); at 4 months (odds ratio = 2.51 [95% CI 1.00–6.30]); and at 12 months (odds ratio = 3.49 [95% CI 1.31 to 9.23]).</p> <p>Mortality: No significant differences between the 2 groups at 4 months. Intervention 16 deaths vs control 18 deaths (<math>p=0.591</math>) at 12 months.</p> <p>Return to same ADL performance level (using the Katz index) as before fracture: There were no significant differences between the 2 groups at 4 months (intervention 56/92 [61%] vs control 39/82 [48%], <math>p=0.078</math>). (Table VI) The intervention group were significantly more likely than the control group to return to the same ADL before fracture at 12 months (intervention</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>multidisciplinary postoperative rehabilitation programme.)</p> <ul style="list-style-type: none"> <li>• Describe intervention - The intervention involved comprehensive geriatric assessment and rehabilitation. Early mobilisation with daily training was provided to participants during their hospital stay.</li> <li>• Delivered by - The intervention was delivered by the multidisciplinary team (nurses, physiotherapists, occupational therapists, dietitians, geriatricians).</li> <li>• Delivered to - The intervention was delivered to participants allocated to a multidisciplinary postoperative rehabilitation programme in a geriatric ward.</li> <li>• Duration, frequency, intensity, etc. – Not reported.</li> </ul>	<p>49/84 [58%] vs control 27/76 [36%], p=0.004)</p> <p><b>Statistical data – service outcomes -</b></p> <p>Length of hospital stay: The intervention group were significantly more likely than the control group to have a shorter inpatient stay; intervention 30 days (SD 18.1) vs. control 40 days (SD 40.6), p=0.028.</p> <p>Readmissions up to 30 days after discharge: No significant differences between the 2 groups - intervention 4 readmissions vs. control 5 readmissions, p=0.734.</p> <p>Readmissions throughout whole study period: No significant differences between the 2 groups - intervention 38 readmissions vs control 30 readmissions, p=0.484.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Key components and objectives of intervention - The overall objective of the intervention was to improve performance in activities of daily living and mobility.</li> <li>• Content/session titles - Includes: Individual care planning, prevention and treatment of complications, nutrition, rehabilitation which also involves early mobilisation with daily training was provided during the hospital stay., home visit by occupational therapist and occupational therapist who co-operated with colleagues working in community service after discharge from hospital. The PT or OT followed up all patients with a telephone call 2 weeks after discharge and a home visit 4 months postoperatively. A physician met the patients 4 months postoperatively to detect and prevent complications.</li> </ul>	<p><b>Narrative findings</b> - Despite a shorter in-hospital stay after surgery, significantly more participants in the intervention group had regained independence in personal activities of daily living performance at 4 and 12 months. Those in the intervention group had also gained the ability to walk independently without walking aids by 4 and 12 months.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Location/place of delivery - The intervention was delivered at a geriatric unit.</li> </ul> <p><b>Comparison intervention:</b> The comparison intervention was delivered at a specialist orthopaedic unit, following conventional post-operative routines. (No dietitian, no corresponding teamwork, individualised care planning not routinely used).</p> <p><b>Outcomes measured:</b></p> <p>Service user related outcomes</p> <ul style="list-style-type: none"> <li>• Living independently.</li> <li>• Walking ability (registered according to the Swedish version - 21 of Clinical Outcome Variables.</li> <li>• Functional status of activities of daily living (Staircase of Activities of Daily Living and Katz Activities of Daily Living index).</li> </ul>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Cognitive status (Mini Mental State Examination)</li> <li>• Depression (Geriatric Depression Scale).</li> <li>• Vision.</li> <li>• Hearing.</li> </ul> <p>Service outcomes</p> <ul style="list-style-type: none"> <li>• In-hospital days after discharge.</li> <li>• Readmissions.</li> </ul> <p><b>Follow-up:</b> Four and 12 months.</p> <p><b>Costs?</b> No.</p>		

**7. Young J, Green J, Forster A et al. (2007) Postacute care for older people in community hospitals: A multicenter randomized, controlled trial. Journal of the American Geriatrics Society 55: 1995-2002**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The study aims to ‘... compare the effects of community hospital care on independence for older people needing rehabilitation with that of general hospital care’</p>	<p><b>Participants:</b> Service users and their families, partners and carers – Elderly patients with an acute illness who had been ‘... emergently admitted to elderly care departments (four</p>	<p>NB. Statistical analysis of between group differences is only reported for change scores in certain outcomes over a small number of time horizons.</p>	<p><b>Overall assessment of internal validity:</b></p> <p>-</p> <p>Due to the high number of eligible patients who did not</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>(p1995). The authors hypothesise that elderly patients transferred to community hospital care would achieve greater independence than those treated in elderly care departments.</p> <p><b>Methodology:</b> Randomised controlled trial.</p> <p><b>Country:</b> United Kingdom – Midlands and north of England.</p> <p><b>Source of funding:</b></p> <ul style="list-style-type: none"> <li>• Government - Department of Health.</li> <li>• Charity - Medical Research Council. The paper also includes data from an earlier study that was funded by The Health Foundation.</li> </ul>	<p>general hospital sites) or a combined elderly and medical unit (one general hospital site)...’ (p1996). Inclusion criteria were - residence within catchment area of a participating community hospital; and deemed to be medically stable with a need for postacute rehabilitation care before expected discharge home (in opinion of senior attending physician).</p> <p>Exclusion criteria were - patients with signs of medical instability (e.g. at rest breathlessness, chest pain within past 48 hours, need for intravenous medication, or pyrexia); drowsy or unconscious patients; patients in need of stroke rehabilitation or specialist care or treatment from another department (e.g. surgery or coronary care); and patients in need of a new</p>	<p><b>Statistical data - service user related outcomes -</b> Anxiety (measured using the Hospital Anxiety and Depression Scale) Between group differences in change scores between baseline and 1 week post discharge from control/intervention hospital: Participants in the intervention group had significantly smaller change scores on a measure of anxiety than those in the intervention group (median difference = 1, 0 to 2 95% Confidence Interval, Mann–Whitney U-test p=0.03). NB No further analyses reported.</p> <p>Summary scores at 1 week post-discharge: There was a difference in favour of the control group; intervention n=208, median score 5 (1-8</p>	<p>participate; high rates of attrition; a relatively high number of control group participants who were transferred to a study community hospital rather than receiving care as usual, or after receiving care as usual were then transferred to non-participating community hospitals, intermediate care facilities or rehabilitation facilities; and blinding concerns it is not possible to award a higher quality rating to this study.</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall assessment of validity:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>nursing home or residential home placement.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age – Intervention – median age 86 years (81–90 IQR). Control – median age 86 years (82–90 IQR).</li> <li>• Sex – Intervention – female n=197 (70.4%), male n=83 (29.6%). Control - female n=141 (67.1%), male n=69 (32.9%).</li> <li>• Ethnicity – Not reported.</li> <li>• Religion/belief - Not reported.</li> <li>• Disability - Not reported.</li> <li>• Long term health condition - Not reported.</li> <li>• Socioeconomic position – Intervention – living alone n=185 (66.1%); does not live alone n=81 (28.9%); lives in care n=14 (5.0%). Control - living alone n=154 (73.3%); does not live alone n= 48 (22.9%); lives in care n= 8 (3.8%).</li> </ul>	<p>IQR) vs. control n=150, median score 4 (2-8 IQR). Summary scores at 3 months post-randomisation: There were no differences in scores; intervention n=183, median score 4 (2-7 IQR) vs. control n=128, median score 4 (2-7 IQR).</p> <p>Summary scores at 6 months post-randomisation: There were no differences in scores; intervention n=170, median score 4 (1-7 IQR) vs. control n=117, median score 4 (2-7 IQR).</p> <p>Depression (measured using the Hospital Anxiety and Depression Scale) - Summary scores at 1 week post-discharge: There were no differences in scores; intervention n=208, median score 6 (3-9 IQR) vs. control n=197, median score 6 (4-10 IQR).</p> <p>Summary scores at 3 months post-randomisation: There</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers: Randomised n=210; received intervention – number unclear; completed 1 week post-discharge assessment n=164; completed 3 months post-randomisation assessment n=149; completed 6 months post-randomisation assessment n=138.</li> <li>• Intervention numbers: Randomised n=280; received intervention n=233; completed 1 week post-discharge assessment n=230; completed 3 months post-randomisation assessment n=216; completed 6 months post-randomisation assessment n=195.</li> <li>• Sample size: Randomised n=490; received intervention n=XX; completed 1 week post-discharge assessment n=394; completed 3 months</li> </ul>	<p>were no differences in scores; intervention n=183, median score 7 (4-10 IQR) vs. control n=128, median score 7 (5-9 IQR).  Summary scores at 6 months post-randomisation: There was a difference in favour of the intervention group; intervention n=170, median score 6 (4-9 IQR) vs. control n=117, median score 7 (4-9 IQR).  NB No analyses reported.</p> <p>Functional activity restriction (measured using the Barthel Index) -  Summary scores at 1 week post-discharge: There were no differences in scores; intervention n=229, median score 16 (13-18 IQR) vs. control n=164, median score 16 (13-18 IQR).  Summary scores at 3 months post-randomisation: There were no differences in scores; intervention n=216,</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>post-randomisation assessment n=365; completed 6 months post-randomisation assessment n=333.</p> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Bed based intermediate care.</li> <li>• Describe intervention - The authors describe the intervention as ‘... multidisciplinary team care for older people in community hospitals’ (p1995). However these interventions were delivered at 7 community hospitals and appear to be pre-existing services.</li> <li>• Delivered by - Few details are provided, however the authors note that the approach to care allowed involvement from social service professionals and therapists. Medical leadership at the community hospitals was provided by</li> </ul>	<p>median score 16 (12-18 IQR) vs. control n=149, median score 16 (13-19 IQR). Summary scores at 6 months post-randomisation: There were no differences in scores; intervention n=195, median score 16 (13-18 IQR) vs. control n=138, median score 16 (12-19 IQR). NB No analyses reported.</p> <p>Independence (measured using the Nottingham Extended Activities of Daily Living Scale) - Between group differences at 6 months: Participants in the intervention group had significantly larger change scores (time horizon not clearly reported) on a measure of independence than participants in the control group (mean difference = 3.27, 0.26 to 6.28 95% CI, p=0.03). After removal of data from an outlier patient, this difference</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>consultant geriatricians and general practitioners.</p> <ul style="list-style-type: none"> <li>Delivered to - Elderly patients with an acute illness who had been ‘... emergently admitted to elderly care departments (four general hospital sites) or a combined elderly and medical unit (one general hospital site)...’ (p1996).</li> <li>Duration, frequency, intensity, etc. - No details on the intensity or frequency of treatments received by community hospital patients are provided in the paper. The authors report that the average length of stay in the participating community hospitals was between 18 and 30 days however the range for each hospital is not reported in this paper and it seems likely that some participants may have stayed for longer than 30 days and there is no</li> </ul>	<p>remained significant (mean difference = 2.98, 0.06–5.91 95% CI, p=0.046). Mann–Whitney U-tests (after assigning the worst score on this measure to patients who had died) also showed that this difference was significant (p=0.03). NB No further analyses reported.</p> <p>Summary scores at 1 week post discharge from control/intervention hospital: There was a difference in favour of the intervention group; intervention n=230, median score 16 (8-25 IQR) vs. control n=163, median score 14 (7-26 IQR). Summary scores at 3 months post-randomisation: There was a difference in favour of the intervention group; intervention n=216, median score 19 (7-32 IQR) vs. control n=148, median score 17 (7-31 IQR).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>indication that upper limits on length of stay were set.</p> <ul style="list-style-type: none"> <li>• Key components and objectives of intervention - The authors' report that the care provided in community hospitals took a 'multidisciplinary rehabilitation approach' and incorporated multidisciplinary assessment and treatment and individualized care plans (p1996-7).</li> <li>• Location/place of delivery - The intervention was provided across 7 community hospitals in the midlands and the north of England. These ranged in size from a 16-bed unit to a 100-bed unit (although only 42 beds were available to the trial at this setting). 1 of these units also provided palliative care, whilst 2 are reported to also have self-contained apartments on site (although it is not clear whether participants at these</li> </ul>	<p>Summary scores at 6 months post-randomisation: There were no differences in scores; intervention n=195, median score 20 (9-32 IQR) vs. control n=138, median score 20 (6-32 IQR).</p> <p>Perceived health state - energy (measured using the Nottingham Health Profile) - Summary scores at 1 week post-discharge: There were no differences in scores; intervention n=214, median score 61 (24-100 IQR). Control n=156, median score 61 (24-100 IQR).</p> <p>Summary scores at 3 months post-randomisation: There were no differences in scores; intervention n=191, median score 61 (24-100 IQR). Control n=133, median score 61 (24-100 IQR).</p> <p>Summary scores at 6 months post-randomisation: There were no differences in scores; intervention n=178,</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>sites had access to these). Three of the community hospitals are described as rural whilst 4 are described as urban.</p> <p><b>Comparison intervention:</b> Participants randomised to the control group received usual care, which the authors' state usually '... consisted primarily of an extended general hospital stay with multidisciplinary care but could include transfer to other postacute services according to existing local operational policies' (p1997). It should be noted that a number of participants in the control group were therefore transferred to an 'intermediate care placement' (n=2); a non-participating community hospital (n=11); and a rehabilitation unit (n=3). The average length of stay in the participating general hospitals was between 7 and 12 days</p>	<p>median score 61 (24-100 IQR). Control n=122, median score 61 (24-100 IQR). NB No analyses reported.</p> <p>Perceived health state - pain (measured using the Nottingham Health Profile) - Summary scores at 1 week post-discharge: There was a difference in favour of the intervention group; intervention n=213, median score 11 (0-42 IQR). Control n=156, median score 13 (0-45 IQR).</p> <p>Summary scores at 3 months post-randomisation: There were no differences in scores; intervention n=191, median score 11 (0-33 IQR). Control n=133, median score 11 (0-41 IQR).</p> <p>Summary scores at 6 months post-randomisation: There was a difference in favour of the control group; intervention n=178, median score 11 (0-</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>however as with the intervention it seems likely that participants may have remained in hospital for longer, particularly given the authors description of usual care as involving an extended stay.</p> <p><b>Outcomes measured:</b> Service user related outcomes</p> <ul style="list-style-type: none"> <li>• Anxiety was measured using the Hospital Anxiety and Depression Scale (0-21, higher scores correspond to higher levels of anxiety).</li> <li>• Depression was measured using the Hospital Anxiety and Depression Scale (0-21, higher scores correspond to higher levels of depression).</li> <li>• Functional activity restriction was measured using the Barthel Index (0-20, lower scores correspond to increased levels of restriction).</li> <li>• Independence was measured using the Nottingham Extended</li> </ul>	<p>42 IQR). Control n=122, median score 9 (0-35 IQR). NB No analyses reported.</p> <p>Perceived health state - emotion (measured using the Nottingham Health Profile) Summary scores at 1 week post-discharge: There was a difference in favour of the intervention group; intervention n=212, median score 16 (0-39 IQR). Control n=156, median score 18 (0-45 IQR).</p> <p>Summary scores at 3 months post-randomisation: There was a difference in favour of the control group; intervention n=191, median score 17 (0-44 IQR). Control n=133, median score 14 (0-43 IQR).</p> <p>Summary scores at 6 months post-randomisation: There was a difference in favour of the intervention group; intervention n=178, median score 14 (0-33 IQR). Control</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>Activities of Daily Living Scale (0-66, lower scores correspond to lower levels of independence).</p> <ul style="list-style-type: none"> <li>• Perceived health state was measured using the Nottingham Health Profile (0-100, higher scores correspond to lower perceived health).</li> <li>• Mortality (source of data not reported).</li> <li>• Place of residence (source of data not reported).</li> </ul> <p>Satisfaction with services –</p> <ul style="list-style-type: none"> <li>• Service satisfaction (scale unclear).</li> </ul> <p><b>Follow-up:</b> Participants were assessed 1 week after control/intervention hospital discharge, 3 months post-randomisation, 6 months post-randomisation however statistical analysis of between group differences is only reported for certain outcomes</p>	<p>n=122, median score 16 (0-38 IQR). NB No analyses reported.</p> <p>Perceived health state - sleep (measured using the Nottingham Health Profile) - Summary scores at 1 week post-discharge: There were no differences in scores; intervention n=213, median score 22 (0-62 IQR). Control n=156, median score 22 (0-50 IQR).</p> <p>Summary scores at 3 months post-randomisation: There were no differences in scores; intervention n=191, median score 22 (0-62 IQR). Control n=133, median score 22 (0-50 IQR).</p> <p>Summary scores at 6 months post-randomisation: There was a difference in favour of the control group; intervention n=178, median score 22 (0-62 IQR). Control n=122, median score 19 (0-45 IQR). NB No analyses reported.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	at a small number of time points.	<p>Perceived health state - isolation (measured using the Nottingham Health Profile) - Summary scores at 1 week post-discharge: There was a difference in favour of the intervention; intervention n=212, median score 20 (0-35 IQR). Control n=156, median score 21 (0-23 IQR). Summary scores at 3 months post-randomisation: There were no differences in scores; intervention n=191, median score 22 (0-42 IQR). Control n=133, median score 22 (0-39 IQR). Summary scores at 6 months post-randomisation: There was a difference in favour of the intervention; intervention n=178, median score 0 (0-23 IQR). Control n=122, median score 22 (0-41 IQR). NB No analyses reported.</p> <p>Mortality</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>The proportion of participants in the intervention group who had died before the 6 month follow-up assessment was lower than that in the control group, however this difference was not significant (intervention 26.1% [n=73] vs. control 30.5% [n=64]; difference = - 4.4%, 95% CI 12.5 to 3.7%; p=0.33). NB No further analyses reported.</p> <p>Place of residence - The proportion of participants living at home prior to hospital admission who were then admitted to a care home or had died before discharge from the control/intervention hospital was lower in the intervention group than in the control group, however this difference was not significant (intervention 24.9% [n=66] vs. control 32.8% [n=66]; difference = - 7.9%; 95% CI - 16.2 to 0.3; p=0.08).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>The proportion of participants living at home prior to hospital admission who were still living at home was higher in the intervention group than in the control group, however this difference was not significant (intervention n=143/254, 56.3% vs. n=101/194, 52.1%, difference = 4.2%; -5.1 to 13.5% 95% CI, p=0.426). NB No further analyses reported.</p> <p><b>Statistical data - satisfaction with services -</b> Satisfaction with services (scale unclear) - Participants in the intervention group were significantly more likely to agree with the statement 'I am happy with the amount of recovery I have made' (odds ratio = 2.12; 95% CI 1.30 to 3.46; p=0.004).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>NB No further analyses reported.</p> <p><b>Narrative findings - service user related outcomes</b>  One week after discharge from the control/intervention, participants in the intervention group had significantly smaller change scores (baseline to 1 week post-discharge) on a measure of anxiety (Hospital Anxiety and Depression Scale) than those in the control group. Follow-up scores at 1 week post-discharge showed a difference in favour of the control group. There were no differences in median follow-up scores on this measure at 3 months post-randomisation or at 6 months post-randomisation.</p> <p>There were no differences in follow-up scores on a measure of depression</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>(Hospital Anxiety and Depression Scale) 1 week post-discharge, or at 3 months post-randomisation. At 6 months post-randomisation there was a difference between follow-up scores in favour of the intervention.</p> <p>There were no differences in follow-up scores on a measure of functional activity restriction (Barthel Index) at 1 week post-discharge; at 3 months post-randomisation; or at 6 months post-randomisation.</p> <p>At 6 months follow-up, participants in the intervention group had significantly larger change scores (time horizon not reported) on a measure of independence (Nottingham Extended Activities of Daily Living Scale) than those in the control group. After</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>removal of data from an outlier patient, this difference remained significant. Mann–Whitney U-tests (after assigning the worst score on this measure to patients who had died) also showed that this difference was significant. There were differences in follow-up scores on this measure in favour of the intervention at 1 week post-discharge; at 3 months post-randomisation. At 6 months post-randomisation there were no differences in follow-up scores.</p> <p>There were no differences in follow-up scores on a measure of perceived energy levels (Nottingham Health Profile - energy) at 1 week post-discharge; at 3 months post-randomisation; or at 6 months post-randomisation.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>At 1 week post-discharge there was a difference between follow-up scores on a measure of perceptions of pain (Nottingham Health Profile – pain) in favour of the intervention. At 3 months post-randomisation there were no differences in follow-up scores. At 6 months post-randomisation there was a difference in follow-up scores in favour of the control.</p> <p>At 1 week post-discharge there was a difference in follow-up scores on a measure of perceived emotional level (Nottingham Health Profile – emotion) in favour of the intervention. There was also a difference in favour of the intervention at 6 months post-randomisation; however at 3 months post-randomisation the difference was in favour of the control.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>There were no differences in follow-up scores on a measure of perceived sleep levels (Nottingham Health Profile – sleep) at 1 week post-discharge; or at 3 months post-randomisation. At 6 months post-randomisation there was a difference in scores in favour of the control.</p> <p>At 1 week post-discharge there was a difference in follow-up scores on a measure of perceived isolation (Nottingham Health Profile – isolation) in favour of the intervention. At 3 months post-randomisation there were no differences in scores. At 6 months post-randomisation there was a difference in scores in favour of the intervention.</p> <p>The proportion of participants in the intervention group who had died before the 6 month</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>follow-up assessment was lower than that in the control group, however this difference was not significant.</p> <p>The proportion of participants living at home prior to hospital admission who were then admitted to a care home or had died before discharge from the control/intervention hospital was lower in the intervention group than in the control group, however this difference was not significant.</p> <p>The proportion of participants living at home prior to hospital admission who were still living at home was higher in the intervention group than in the control group, however this difference was not significant.</p> <p><b>Narrative findings - Satisfaction with services</b> Participants in the intervention group were significantly more likely to</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		agree with the statement 'I am happy with the amount of recovery I have made'.	

## Review question 2 – Findings tables – the views and experiences of people using services, their families and carers

### 1. Ariss S (2014) National audit for intermediate care: Patient reported experiences, 2014. Sheffield: University of Sheffield

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> To obtain views and experiences from people using intermediate care by asking the following survey question: 'Do you feel that there is something that could have made your experience of the service better?'</p> <p><b>Methodology:</b> Survey.</p> <p><b>Country:</b> UK – England.</p> <p><b>Source of funding:</b> Government.</p>	<p><b>Participants:</b> Service users and their families, partners and carers - People using intermediate care (including bed based intermediate care).</p> <p><b>Sample size:</b> 908 (345 of which were people using bed based intermediate care).</p> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Describe intervention - Bed based intermediate care. No further details provided.</li> <li>• Delivered by – Not reported.</li> <li>• Duration, frequency, intensity, etc. - Not reported.</li> </ul>	<p>Statements about ways that the service might be improved were coded into 8 distinct themes, which emerged from the data. They are listed here in descending order, starting with those cited most frequently. NB The document does not include page numbers to reference any quotes reported below.</p> <p>Personal communication and attention Comments received in relation to this theme included reports of</p>	<p><b>Overall assessment of internal validity:</b> -</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> -</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Key components and objectives of intervention - Not reported.</li> <li>• Location/place of delivery - Not reported.</li> </ul>	<p>dissatisfaction with the provision of information regarding services or the care which service users were likely to receive (often reported as inconsistent) as well as the amount of information provided at discharge:</p> <p>“I was led to believe that just 3/4days at rehabilitation centre would be enough but clearly this was incorrect so I did not make sufficient arrangements for my stay for example clothes, financial matter [sic] etc.”</p> <p>“It would be useful to have a discharge packet giving the available support organization outside of the hospital.”</p> <p>Other respondents felt that staff had been disrespectful to them or had spoken in an inappropriate manner. Some</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>respondents felt that they had not been listened to, whilst others reported that their needs had not been properly understood. Respondents also suggested that communication with the families of service users needed to be improved and that staff should be more responsive to service users.</p> <p>Facilities Comments included in this theme related to entertainment and food as well as the layout of units, and the toilet and washing facilities available. Service users were particularly concerned about the lack of activities and alternative spaces (including access to a garden or the local area) and privacy levels (for example when using a commode). Other respondents commented on the location of the intermediate care unit:</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>“Putting rehab clients together on the same floor, instead of mixing them with dementia/nursing home permanent clients.”</p> <p>The author notes that hydration and nutrition were not always adequately addressed and some respondents reported little consideration of dietary needs:</p> <p>“My wife is Coeliac and diabetic they had no idea on how or what food she required. Bread and various other foods were supplied by myself.”</p> <p>Joined-up and appropriate services It should be noted that many of the quotes included to support this theme do not appear to relate to bed-based intermediate care, and</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>instead seem more likely to be descriptions of home care/rehabilitation provided in the home. However, the author reports that comments relating to this theme tended to focus on discharge arrangements and the extent to which services communicated with each other and the impact this had on co-ordinated care.</p> <p>“My daughter was informed that she would be involved in a meeting prior to me coming home, to discuss my needs. This didn't happen, on my release there was no "hand over" or staff around to speak to my family. More communication between family and staff would benefit your service.”</p> <p>“Carers were set up to help prepare meals but no information was given to get look at how I was going to get</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>food in my house and with no physio/ help this was a problem.”</p> <p>“Over whelming sense that medical/ after care and Reablement exist in separate bubbles. Insufficient medical input after discharge from # operative procedure. Poor execution.”</p> <p>Other issues brought up by respondents included waiting times and accurate information regarding these, and continuity of care.</p> <p>The author reports that a small number of comments were received about provision of information on other services and the knowledge of staff regarding these.</p> <p>Staffing Many participants are reported to have commented</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>on staff shortages and the need for staff to have specific skills or for certain professions to be involved in care:</p> <p>“Staff are all kind, gentle, helpful and full of fun. I think they have too much to do. Could do with more staff.”</p> <p>“Lack of therapy at weekends.”</p> <p>“Compassionate nursing was not there, nurses were doing job without any care.”</p> <p>The author also highlights that agency workers and night shift staff were sometimes mentioned specifically:</p> <p>“Some of the agency nurses not to standard of the permanent nurses who were excellent.”</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Personal care The majority of comments received in relation to this theme are reported to have focused on bathing, help using the toilet, and mobility.</p> <p>“More frequent bath /shower (One a week not enough!!)” “I did not get a shower although I requested for one.” “Would have liked to have been offered a shower more frequently.”</p> <p>“Sitting in a chair unfree to move is not good for morale.” “Given more time to exercise.” “They should have made me walk more then they did.”</p> <p>“Felt I could have walked more, but appreciate I did walk down for meals.”</p> <p>“Yes too much sitting/lying around.”</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Some respondents also highlighted assistance at meal times as an area that could be improved:</p> <p>“More help given at breakfast times, where people were struggling with their hands.”</p> <p>“More assistance and care with eating is required. Just cutting up food is not sufficient- help and encouragement is necessary during the whole meal. My husband has very little use in his hands and consequently manages with great difficulty to eat only a small part of every meal.”</p> <p>“On a good number of days dad’s food was still in front of him, result losing 3 stones.”</p> <p>Therapy and assessment The author highlights that a significant number of comments were made</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>specifically in relation to perceived insufficiencies in the amount of physiotherapy provided. Other respondents commented on the need for more exercise or the assistance they felt they needed to be able to walk. The author suggests that this is indicative of inappropriate skill mixes at some facilities.</p> <p>“I would have liked to do more work on the stairs.”</p> <p>“More extensive physio, probably may have helped me when I was discharged home. In total had 5 treatments of physio following a total hip replacement!!”</p> <p>“More physio visits because that was the main reason for his stay and only had 2 sessions in 2 weeks.”</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		"More time with the physiotherapist and teaching of exercises."	

**2. Benten J and Spalding N (2008) Intermediate care: What are service users' experiences of rehabilitation? Quality in Ageing and Older Adults 9: 4-14**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The researchers aimed to ‘...explore service users’ experiences of a 22-bedded intermediate care service’ (p4). Out of 6 themes that emerged from this research, this paper presents findings in relation to 1 and the specific question – ‘... did the intermediate care unit provide rehabilitation that met the needs of service users?’ (p5).</p> <p><b>Methodology:</b> Qualitative – semi-structured interviews.</p> <p><b>Country:</b> United Kingdom – The study reports patient experiences of an intermediate</p>	<p><b>Participants:</b> Service users and their families, partners and carers – Service users being discharged from an intermediate care unit in the east of England within the study’s data collection period (four-months).</p> <p>Participants were eligible if they were aged 65 or more, had stayed at the unit for a minimum of 2 weeks, intended to return to their home, and had been referred to the facility for rehabilitation. Participants were excluded if they were medically unstable or ‘... not</p>	<p>NB. The authors report that 6 themes emerged from their research conducted with service users, however this paper only reports on 1 of these themes and the corresponding research question – ‘... did the intermediate care unit provide rehabilitation that met the needs of service users?’ (p5).</p> <p>‘Users’ understanding’ (p7) The authors report that none of the participants had received any information regarding intermediate care when they were admitted to hospital, and that all</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>care facility in the east of England.</p> <p><b>Source of funding:</b> Not reported.</p>	<p>psychologically orientated at most times ...' (p6).</p> <p>The authors do not state what (if any) eligibility criteria were specified for the facility itself. Participants had been admitted to acute hospital for a variety of reasons including aneurysm, diabetes related infection, elective surgery, fractures, and myocardial infarctions, etc.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age – Although inclusion criteria for the study specified that participants should be aged 65 or above, the ages of participants ranged between 64 and 83 years of age.</li> <li>• Sex – The majority of participants were female (n=6).</li> <li>• Ethnicity – The authors report that the sample did not include any Black or "... ethnic communities ..." (p12).</li> </ul>	<p>participants had also been unaware of the unit before their transfer there was suggested.</p> <p>Five participants are reported to have felt that the information they had subsequently received in relation to the unit and why it was deemed appropriate for them was minimal:</p> <p>"They said: 'We can let you go to the community ward' and I said 'What is that?' and 'Where is that?' and because I had a feeling at first that it was where the very very old people were and perhaps there were some there... that weren't all there up top, I thought I don't want to go to a ward like that. Well, they didn't say too much about it, they simply said they had got this community ward, 'It's very pleasant.' (Participant 1, p7).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Religion/belief - Not reported.</li> <li>• Disability - Not reported.</li> <li>• Long term health condition - Not reported.</li> <li>• Socioeconomic position – Not reported.</li> </ul> <p><b>Sample size:</b> n=8.</p> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category – Bed based intermediate care.</li> <li>• Describe intervention – Intermediate care provided in an impatient unit to participants discharged from an acute hospital ward before returning to their own home.</li> <li>• Delivered by – Discharge co-ordinator (1.0 whole-time equivalent); healthcare assistants (12 whole-time equivalent); qualified nurses (6.3 whole-time equivalent); occupational therapist (0.6 whole-time equivalent);</li> </ul>	<p>“They said: ‘You are going to the community centre.’ But I had no idea what it was ...” (Participant 6, p7).</p> <p>Three participants are reported to have felt involved in the decision-making process (one of whom had received an information leaflet explaining the unit).</p> <p>The authors report that when participants were asked why they thought they had been transferred to the facility; many participants cited their immobility. Other suggestions included access to specialist nurses, or as an interim measure whilst property adaptations or home care packages were arranged. The authors note that a number of participants suggested the need to free up acute care beds as the main reason for their transfer to the facility (in contrast to</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>pharmacy technician (1.0 whole-time equivalent); physiotherapy technician (1.0 whole-time equivalent); ward clerk (0.8 whole-time equivalent). The authors note that the healthcare assistants and nurses did not receive additional training when recruited. A staff grade doctor who visited the unit on a daily basis provided medical cover and additional services were available when requested (i.e. dietician, social worker, speech and language therapist).</p> <ul style="list-style-type: none"> <li>• Delivered to – Unclear. The authors do not report whether the facility had any eligibility criteria except to note that the service accepted referrals for participants over the age of 18.</li> <li>• Duration, frequency, intensity, etc. – Length of stay for the 8 participants</li> </ul>	<p>an active choice to participate in a rehabilitation programme) and some participants are reported to have referred to themselves as ‘bed-blockers’.</p> <p>‘Assessment and goal setting’ (p8)</p> <p>The majority of participants are reported to have been unaware of any formal assessment of their personal, physical or social needs at admission to the facility and could not recall being involved in setting and prioritising rehabilitation goals. Similarly, participants were unable to explain how staff there had attempted to address their rehabilitation needs and whether their care included an individual treatment plan:</p> <p>“My difficulties were not discussed, not that I</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>ranged between ten and 29 days.</p> <ul style="list-style-type: none"> <li>• Key components and objectives of intervention –</li> <li>• The authors do not provide detail in relation to the care provided at the facility except to report that the units operational policy was: ‘... to reduce pressure on acute hospital beds by providing a comprehensive range of care, treatment, rehabilitation and support services through multi-professional working, for a time limited period of between 1 and 2 weeks up to a maximum of 6 weeks’ (p5). The authors also note that once the patient had been admitted to the facility, staff there had responsibility for planning treatments and arranging discharge.</li> <li>• Content/session titles – N/A.</li> <li>• Location/place of delivery – A 22-bed intermediate care facility in the east of</li> </ul>	<p>remember” (Participant 7, p8).</p> <p>“Well I can’t remember them being discussed with me a lot at all really, they simply started looking after me” (Participant 1, p5).</p> <p>One participant reported that they had tried to understand their progress by looking at notes kept by their bedside, however these had proven to be unhelpful:</p> <p>“Being a nosey parker I kept looking in the notes, but I couldn’t understand them, they were all squiggles. I only knew how I was getting on by how I feel myself. I couldn’t understand what was written down” (Participant 4, p8).</p> <p>‘Interventions’ (p8) The authors note that the culture that participants described at the unit was one</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>England, which had been opened in 2000. The authors' note that the facility is only in use on a temporary basis until construction of a new 32-bed unit is completed.</p>	<p>of 'do it yourself' rather than one of active rehabilitation, with little purposeful activity being undertaken by service users:</p> <p>"We walked around if we felt like it" (Participant 1, p8).</p> <p>Participants who received physiotherapy are reported to have felt that more should have been provided to them; and a patient who had had a lower limb amputated described his time at the facility '... purely in terms of waiting for adaptations to be completed at home. He felt he could have followed up his physiotherapy with healthcare assistants on the ward but never liked to ask them' (Authors p8).</p> <p>The authors also note that when participants were asked to recall activities they had</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>undertaken, the responses included:            “The physio came with a sheet of paper with a number of exercises to do. I did those until I got bored with them. After that I started to walk about by myself” (Participant 5, p8).</p> <p>Provision of occupational therapy was also reported to be mostly limited to home assessment and the provision of equipment, with 2 participants reporting a session in the kitchen in which they made a cup of tea. The authors emphasise that this was the only ‘everyday task’ recalled by participants, and suggest that there was little connection made between needs likely to arise in the participants own home and those activities undertaken at the facility.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Participants are also reported to have viewed the nurses as 'very busy' in the nursing role, a characteristic that the authors' note was unlikely to enable independence.</p> <p>The authors report that service users described daily life at the facility as mainly inactive and with no clear focus of rehabilitation on the participants needs once they had returned home:</p> <p>"I've just been content to sit really" (Participant 8, p8).</p> <p>Similarly, the authors report that the emphasis on active and healthy living was absent from participants' experiences in the facility. They report that the son of 1 participant (a non-insulin-dependent diabetic) sometimes cooked fried breakfast for him, which the authors suggest is indicative</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>of a poor understanding of dietary needs.</p> <p>The authors also report that some patients had experienced disempowering attitudes at the unit:            “I have a problem; I am incontinent and have been for years. As I took pads in with me, this was not picked up; I was put down as continent. On the community unit when my pads ran out, 1 nurse would only give me 1 pad at a time, others would give me a day’s supply. I am supposed to have 5 a day and a night pad. It felt very demeaning to have to almost beg for one” (Participant 2, p8).</p> <p>‘Transfer home’ (p9)            There were mixed views in relation to discharge from the facility and the authors contrast responses in which transfers were well-planned and involved participants’</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>families, to those in which confusion had arisen:</p> <p>“I was given quite a bit of notice... I had the home assessment and then they (daughters) went on holiday. When they came back it was when I came home and one of them came and stayed with me for a couple of days” (Participant 5, p9).</p> <p>“The week before they said I could come home on the Tuesday or Friday and I felt it was more likely to be the Friday. But on the Monday of that week, they said you can go home on the Wednesday” (Participant 2, p9).</p> <p>The authors emphasise that all participants were satisfied with their stay at the unit and reported that they found the staff there to be friendly and kind; however they caution that this positive feedback</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>should be considered in the context of a general lack of understanding in relation to the unit's purpose and its role in their rehabilitation.</p> <p>The authors report (with little explanation) that participants were asked to reflect on their needs after discharge to their own home; if they had felt confident before discharge; and if (after returning to their own home) there was anything they felt should have been addressed during their stay at the facility:</p> <p>“The only difficulty is because I was getting my meals brought to me in the hospital and here I have to stand and make my own meals” (Participant 2, p9).</p> <p>“When I first came home, I only sat and went up the stairs at night. I used to shake at the bottom before I</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>went and shake at the top when I got there. But I don't do that any more. I can get up and down without shaking, so my legs are getting stronger... I am getting more into the kitchen" (Participant 8, p9).</p> <p>"Yes, I was definitely ready to come home. I had had the visit one afternoon with the occupational therapist, over the loo and the door and everything... It's been alright. It's been better than I thought it would be" (Participant 7, p10).</p>	

## Review question 2 – Findings tables – Health, social care and other practitioners' views and experiences

### 1. Millar AN, Hughes CM, Ryan C (2015) "It's very complicated": A qualitative study of medicines management in intermediate care facilities in Northern Ireland. *Biomed Central Health Services Research* 15: 216

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<b>Study aim:</b> The study aimed to explore healthcare workers' and	<b>Participants:</b>	Three overarching themes were identified:	<b>Overall assessment of internal validity:</b>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>patients' views and attitudes towards medicines management services in intermediate care facilities in Northern Ireland.</p> <p><b>Methodology:</b> Qualitative study. The study used qualitative methodology. Semi-structured interviews were conducted and analysed using a comparative approach.</p> <p><b>Country:</b> UK. Northern Ireland.</p> <p><b>Source of funding:</b> Government - Department for Employment and Learning, Northern Ireland.</p>	<ul style="list-style-type: none"> <li>• Service users and their families, partners and carers - Participants included service users.</li> <li>• Professionals/practitioners - Participants included healthcare workers from various intermediate care settings.</li> </ul> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age – Not reported.</li> <li>• Sex - Nine service users were male and 9 were female. This is not reported for healthcare workers.</li> <li>• Ethnicity – Not reported.</li> <li>• Religion/belief – Not reported.</li> <li>• Disability – Not reported.</li> <li>• Long term health condition – Not reported.</li> <li>• Sexual orientation – Not reported.</li> <li>• Socioeconomic position – Not reported.</li> </ul>	<p>1. Concept and reality - Healthcare workers noted the discrepancies between the concept and reality of intermediate care. For example, most identified the service as 'rehabilitation' as they viewed the terminology of intermediate care to be poorly understood in the wider health service: "It's a new word... I don't like the term 'intermediate care', I would sit more comfortable with it being a medical rehabilitation ward for older people" (p4).</p> <p>Those working in nursing and residential homes felt that although the concept was good, "from the ground it is not running properly" (p5). This was in contrast to patients, who frequently expressed positive attitudes towards the intermediate care setting: "I think it's this place that has helped me a lot..."</p>	<p>+</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p><b>Sample size:</b> A total of 43 participants (25 healthcare workers and 18 patients) were recruited to the study.</p>	<p>you just feel like very at home already" (p5).</p> <p>2. Setting and supply The settings in which intermediate care was delivered were found to be varied, dictating both medical care provision and the prescribing of medicines. For example, many healthcare workers found that 'off-site' supplies posed logistical challenges, delaying the administration of drugs and overall process. Patients, on the other hand, had no knowledge of who was responsible for prescribing their medicines and were not concerned about their supply: "They just give them to me, I don't know where they come from" (p5).</p> <p>3. Responsibility and review Responsibility for prescribing and reviewing patients' medicines in intermediate care facilities also varied</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>depending on the setting. Self-administration of medicines was not promoted by healthcare workers due to concerns of patient safety: "it's easier for us to just take control, take charge, we know they're safely stored, we know they've got them..." (p6).</p> <p>Similarly, medication counselling was not routinely provided, as healthcare workers felt that this was not their responsibility and many patients believed this to be unnecessary: "I'm one of those people who just takes the doctor's word for it and assume that he knows best and don't really query it" (p6).</p>	

**2. Regen E, Martin G, Glasby J et al. (2008) Challenges, benefits and weaknesses of intermediate care: Results from five UK case study sites. Health & Social Care in the Community 16: 629–37**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The research was designed to ‘... explore the views of practitioners and managers on the implementation of intermediate care for elderly people across England, including their perceptions of the challenges involved in its implementation, and their assessment of the main benefits and weaknesses of provision’ (p629).</p> <p><b>Methodology: Qualitative:</b> Focus groups and semi-structured interviews.</p> <p><b>Country:</b> UK – England.</p> <p><b>Source of funding:</b></p> <ul style="list-style-type: none"> <li>• Government – Department of Health.</li> <li>• Charity – Medical Research Council.</li> </ul>	<p><b>Participants:</b> Professionals/practitioners – Practitioners and managers working in intermediate care in 1 of 5 primary care trusts in England.</p> <p>Interviews were conducted with individuals involved in the strategic development of intermediate care and intermediate care service managers (medical staff, senior managers, lead professionals and managers of individual services); and focus groups were conducted with practitioners directly involved in care provision (allied health professionals, care assistants, nurses, social workers, etc.).</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age – Not reported.</li> <li>• Sex – Not reported.</li> <li>• Ethnicity – Not reported.</li> </ul>	<p>‘Developing intermediate care – challenges’ (p632) Participants are reported to have identified problems recruiting and retaining both qualified and non-qualified staff as the most significant barriers to the implementation of intermediate care, with inadequate funding and difficulty attracting staff to posts being cited as the main reasons for these. The risk of professional isolation within small teams based in the community, and a low awareness of intermediate care were thought to be key issues for professional staff; whilst participants felt that support staff would be deterred by low wages and unsociable and long hours.</p> <p>“One of the biggest things that has been the problem is the fact that there has been a</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Religion/belief - Not reported.</li> <li>• Disability - Not reported.</li> <li>• Long term health condition - Not reported.</li> <li>• Socioeconomic position – Not reported.</li> </ul> <p><b>Sample size:</b> Interviews n=61 participants; focus groups n=21 participants. Total sample size n=82.</p> <p><b>Intervention:</b> Intervention category – The trusts for which participants worked all provided a range of services that the authors describe as intermediate care. These included sheltered housing, rapid response teams and domiciliary rehabilitation, however only data in relation to bed based intermediate care have been extracted here.</p> <p>The authors report that the sites were ‘... operating in a context whereby a single social</p>	<p>lack of a capacity and by that I mean we have not got the staff levels to offer the service we would want to. It is very difficult to get hold of rehab assistants . . . through one thing and another, be it low money or bad shifts, people don’t necessarily want to do that” (Participant 1, site E, p633).</p> <p>Participants are reported to have identified funding shortages (and non-recurrent short-term funding in particular) as a challenge to the implementation of intermediate care. Medium to long-term service development was reported to be difficult to plan for when short-term contracts were the norm and future funding was uncertain.</p> <p>Participants at all sites are reported to have identified low levels of joint working</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>services department (county- or city-wide) was attempting to work alongside several locality-based PCTs (sites B, C, D, E). The exception was site A where the city-wide PCT was coterminous with social services' (p631).</p> <p>Four of the sites are also reported to have attempted to improve the links between intermediate care and the wider service network by implementing '... a single point of access for referrals to intermediate care. Site A had developed an alternative approach. Here, there was no single point of access. Instead, intermediate care operated as a "managed network" which sought to bring the range of services into a single operating system via closer links between services, agreed pathways of care and clearer access points' (p631).</p>	<p>between health and social care as a significant challenge in the implementation of intermediate care. The authors report that competing strategic attempts to take 'ownership' of intermediate care were particularly apparent at sites C, D and E:</p> <p>"It still feels to me like there's quite a bit of potential in-fighting between social services and [the] PCT about who owns it, who's taking the initiative. Maybe that's at certain levels ... but it shouldn't be like that, it's an integrated service, you can't talk about owning it, it can't be like that" (Participant 5, site E, p633).</p> <p>The authors note that even those areas in which the move towards joint working had been more successful, the tendency for</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Describe intervention – Not reported.</li> <li>• Delivered by – Not reported.</li> <li>• Delivered to – Not reported.</li> <li>• Duration, frequency, intensity, etc. - Not reported.</li> <li>• Key components and objectives of intervention - Not reported.</li> </ul>	<p>organisations to attempt to retain control of budgets had hindered implementation:</p> <p>“There has been very good collaborative work between agencies for a number of years ... but one of the stopping points, if you like, or the barriers to taking that work forward, is different financial budgets, for example. Everybody is all for joint working and collaboration until you start asking people to give over ... money and that is a constant tension and I think perhaps has stood in the way of really making good progress and having a more flexible model” (Participant 15, site A, p633.).</p> <p>Frontline challenges to joint working are reported to have included incompatible information technology systems and varied employment policies.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Non-medical interviewees at 3 sites are reported to have identified a perceived lack of involvement from medical practitioners as a barrier to the implementation and use of intermediate care services. Participants suggested that medical practitioners felt that there was insufficient evidence regarding the effectiveness of intermediate care or thought it potentially discriminated against older people:</p> <p>“The more senior members ... of the medical profession could remember days when older people had been warehoused, so to speak, in environments outside hospital because they were not considered worthy of hospital admission and they didn’t want to go back to those days where people were being basically cared for and</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>denied proper assessment and treatment” (Participant 1, site B, p633).</p> <p>In contrast, a number of interviewees suggested that acute sector clinicians had seen themselves as excluded from the implementation of intermediate care. The authors report that the lack of involvement from general practitioners could be explained by low incentives and high workloads.</p> <p>Some consultant geriatricians reported concerns that intermediate care had been introduced before the evidence base had been established:            “If I need to convince my colleagues, then I think I would need robust evidence. Nowadays, everything is evidence based and unless we develop some evidence and say this is what is</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>happening, it's going to be very difficult to convince the sceptical" (Participant 2, site B, p633).</p> <p>Consultants are also reported to have felt that the emphasis on reducing hospital use by the elderly potentially made intermediate care a discriminatory service.</p> <p>The authors report that the potential for intermediate care to enable allied health practitioners and nurses to move into leadership roles had in some cases been interpreted as a sign that medical involvement was not needed at all. However, consultants are reported to have seen this as something that could lead to higher costs because the length of stay for service users with unmet medical needs would be higher. The authors also report that consultants felt</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>that medical input into intermediate care services made these 'safer', helped to streamline the transition between the acute and intermediate sectors, and reassured other practitioners regarding the care provided there:</p> <p>"It smoothes the working between the acute hospital and the intermediate care unit, and it also means that I can, if you like, re-assure colleagues that it's a proper unit, there's proper medical support as well as the multidisciplinary care and my working across the 2 units hopefully re-assures people that communication is good, the pathways of referral are recognised and so on" (Participant 1, site B, p634).</p> <p>Benefits of intermediate care Participants across all sites are reported to have</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>identified the potential benefits it offered to service users as its main strength (both in terms of experiences and outcomes). Participants suggested that intermediate care was flexible, holistic, patient centred and responsive, attributes which were often contrasted to those of care provided in hospital:</p> <p>“They get like a one-to-one service. If they’re in a hospital base, you get your healthcare assistants with however, many other patients there are in a ward. They get individual attention whether it’s from us, whether it’s from their own district nurse in their own home and they thrive on it” (Participant 24, site A, p634).</p> <p>Participants emphasised the home-like environment of intermediate care, which was seen as a means of</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>increasing independence and confidence, in contrast to care in the hospital which was felt to lead to greater dependency.</p> <p>Participants are also reported to have identified multidisciplinary teamwork as a potential strength of intermediate care that could benefit both practitioners and service users. Participants emphasised the positive impact that support from colleagues and access to a wide range of professional expertise could have. Practitioners are also reported to have welcomed the increased role flexibility provided by intermediate care:</p> <p>“We’re multidisciplinary but we’re also very interdisciplinary. But having said that we know our boundaries so as a nurse going out to see a patient, I</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>would carry out my nursing tasks but I wouldn't just go out there and do my nursing tasks, which would happen on a ward. There wouldn't be such an overlap [on a ward] as there is within the team ... so if they're having to carry out an exercise programme then it would be expected of me as a nurse to go through that exercise programme with them on behalf of the physio" (Participant 5, site A, p634). Practitioners also discussed the job satisfaction they had gained through their involvement in intermediate care, which the authors suggest appeared to be fundamentally linked to the service emphasis on restoring or maintaining independence.</p> <p>Weaknesses of intermediate care Participants at all sites were reported to comment on the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>failure of intermediate care to fulfill its potential as a means of alleviating pressures on the health and social care system.</p> <p>Participants highlighted the limited number of beds and placements, operational hours and staffing levels as key issues in relation to this. Although participants noted the impact which funding had on these issues, the authors also report that the inability to recruit and retain staff had an impact.</p> <p>Participants at all sites are also reported to have identified poor awareness about intermediate care and difficulties in accessing these services as a challenge to under use of these services. Some participants also suggested that the eligibility criteria for intermediate care services were too narrow or that these services ‘cherry-</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>picked' service users, which resulted in an overreliance on more traditional care:</p> <p>“So the experience on the ground, when I talk to people in the hospital and say ... 'This looks like intermediate care to me, did you phone last night? You know, we've been telling you about it', he said, 'Oh that was no good, I phoned and they weren't interested', or 'They said they didn't have any space.' 'I'm losing faith in intermediate care', 'I can't see the point': I get comments like that all the time” (Participant 5, site e, p635).</p> <p>A small number of participants suggested that more needed to be done to build stakeholder confidence in intermediate care and to address concerns regarding perceived risk:</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>“The big cultural thing we found in particular about the intermediate care beds is hospital staff being prepared to take the risk and discharge somebody to something new that is relatively untested and unknown ... So it is starting to overcome those barriers. Part of it is actually once somebody has put a patient through intermediate care then they have got the confidence to do it again” (Participant 16, site D, p635).</p> <p>Another issue raised by participants across all sites was the tendency for intermediate care services to be used inappropriately, with many expressing concern that this was being driven by the need to free up acute care beds rather than providing the care appropriate to enable the individual to recover at their own pace.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Intermediate care services that were poorly integrated with similar services was also highlighted by some participants which the authors report led to difficulties in accessing services, problems in the care pathway and opposition to flexible working. Participants are reported to have viewed this failure to co-ordinate or integrate as symptomatic of the ad-hoc manner in which many services had been developed. The authors also report that participant's knowledge in relation to other intermediate care services and their eligibility criteria were inconsistent.</p> <p>When discussing the range of services on offer some participants are reported to have suggested that elderly people with mental health problems were at a</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		disadvantage due to a lack of input from mental health services into intermediate care. Other participants are reported to have identified more proactive services such as admission avoidance schemes as a more appropriate priority than bed-based services.	

**3. Thomson D and Love H (2013) Exploring the negative social evaluation of patients by specialist physiotherapists working in residential intermediate care. *Physiotherapy* 99: 71-7**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<b>Study aim:</b> The researchers aimed to ‘... gain an understanding of the negative social evaluation of patients by specialist physiotherapists, and to explore possible coping strategies in order to engage patients in appropriately designed rehabilitation programmes’ (p71). The authors go on to explain that ‘negative social evaluation’ is a more acceptable term than ‘difficult’ in	<p><b>Participants:</b> Professionals/practitioners - Senior level physiotherapists specialising in intermediate care working in the greater London area.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age – 29-36 years of age at time of participation.</li> <li>• Sex – Focus group participants – female n=4, male n=1. Interview</li> </ul>	The authors report that participants discussed categories ‘residing’ with the service user (alcohol dependency, inability to accept their condition or adapt, and family involvement which obstructed the process of rehabilitation) and those which ‘resided’ within the context of intermediate care specifically (‘labelling’, the 6 week model, and transfer into	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> + Although this appears to be a generally well-conducted study the lack of information</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>relation to service users who represent an ‘interpersonal’ challenge to practitioners. These practitioners were working at a residential intermediate care facility.</p> <p><b>Methodology:</b> Qualitative. Focus groups and semi-structured interviews.</p> <p><b>Country:</b> United Kingdom – Greater London area.</p> <p><b>Source of funding:</b> Not reported.</p>	<p>participants – female n=4, male n=0.</p> <ul style="list-style-type: none"> <li>• Ethnicity – Not reported.</li> <li>• Religion/belief - Not reported.</li> <li>• Disability - Not reported.</li> <li>• Long term health condition - Not reported.</li> <li>• Socioeconomic position – Not reported.</li> </ul> <p><b>Sample size:</b> Focus group participants n=5. Interview participants n=4. Total sample N=9.</p> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category – Bed based intermediate care.</li> <li>• Describe intervention – Detail in relation to the care provided by the facilities at which participants worked is not provided. However the authors note residential intermediate care is increasingly considered to ‘... represent the adoption</li> </ul>	<p>the service). The authors conclude that these categories contribute to the likelihood that a service user will receive a ‘negative social evaluation’ (the perception that the service user is ‘difficult’ or ‘challenging’). Participants also reported ‘coping strategies’ to address these issues (goal setting, reflective practice and workforce planning).</p> <p>Alcohol dependency The authors report that participants expressed frustration in relation to service users who drank alcohol excessively; particularly in relation to the effect which this had on treatment efficacy:</p> <p>“There are 50 patients that need intermediate care but if you look at it closely, 10 of those are debatable and 10 of those are alcoholics, so the</p>	<p>regarding whether data was double coded and sometimes somewhat unclear links between the data and the conclusions it is not possible to award a higher quality rating to this study.</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>and integration of bio-psychosocial values within health care, including a person-centred care approach' (p71).</p> <ul style="list-style-type: none"> <li>Delivered by – All participants had qualified between 1999 and 2004 and the majority had received their basic training in the United Kingdom (one participant had trained in Malta and one in India. There was a range of qualification levels (BSc, PGcert, MSc) and participants Agenda for Change bands ranged between 6 and 8a. The number of years which participants had specialised in intermediate care for ranged between 3 and six.</li> <li>Delivered to – Detailed characteristics of the service users which participants worked with is not reported, however 3 focus group participants are reported to</li> </ul>	<p>30 should be the ones getting seen by the NHS” (Focus group – Physiotherapist 1, p73).</p> <p>The authors go on to note that participants made assumptions about service users with alcohol dependency issues in relation to their social environment and living arrangements and their ability to perform activities of daily living:</p> <p>“Alcoholism is a thing I personally find quite challenging at times. It means generally that they are relatively unkempt, their gait pattern is usually quite poor (and) trying to get them to use any kind of aid is just not a good idea. And you can't educate them; only tell them to stop drinking” (Interview – Physiotherapist D, p73).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>have a predominant caseload of older people's rehabilitation and 2 are reported to have a predominant caseload of neurological rehabilitation. All interview participants had a predominant caseload of older people's rehabilitation.</p> <ul style="list-style-type: none"> <li>• Duration, frequency, intensity, etc. – Not reported for any of the facilities, however the authors note that the residential intermediate care model is a 6 week therapeutic intervention.</li> <li>• Key components and objectives of intervention – Not reported for any of the facilities, however the authors note in their preliminary discussion that residential intermediate care services have the goals of '... facilitating early hospital discharge, avoiding unnecessary hospital admission and delaying</li> </ul>	<p>Participants reported that service users who continued to consume alcohol whilst staying in intermediate care had been asked to leave and the authors suggest that the issue of alcohol dependency appears to '... provide a conflict for the physiotherapist looking to provide person-centred rehabilitation ...' (Authors, p73).</p> <p>Participants are also reported to have felt that intermediate care teams did not possess the specialist skills required to help service users overcome their reliance on alcohol.</p> <p>'Patients with unrealistic demands due to a failure to accept their situation' (p74)  Participants are reported to have highlighted service user anger regarding their diagnosis as a critical issue:</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>transfer into long-term care ...' (p71).</p> <ul style="list-style-type: none"> <li>• Content/session titles – N/A.</li> <li>• Location/place of delivery – Participants worked at a range of intermediate care facilities in the greater London area however no further details are provided.</li> </ul>	<p>“And then it actually hits home that they can’t actually do the things they thought they’d be able to do and they get quite angry that you’re not doing what you should be doing for them or you’re not experienced enough. So clearly (they think) you’re holding them back and you’re not, obviously” (Interview – Physiotherapist D, p74).</p> <p>The authors also note that participants reported that management of service user expectations regarding recovery impacted on the provision of clinical interventions.</p> <p>‘A patient with an unhelpful family’ (p74) Participants are reported to have regularly commented on the importance of interactions with the families of service users and suggested that family dynamics and the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>expectations of the family were important:</p> <p>“The patient’s family doesn’t kind of help either sometimes. If they think we can get them home and walking, then we need to do it now. Or ... we’re being too harsh ‘Oh, just leave him in bed, he’s tired, he had a stroke ... he needs to rest.’ (They) Don’t really understand what we are trying to do” (Interview – Physiotherapist D, p74).</p> <p>‘Being labelled/external and internal assumptions (p74) The researchers report that physiotherapists made assumptions about service users and the challenges that they may represent based on labels used by practitioners making referrals to intermediate care: “You do start to prejudge people and as soon as</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>someone says you've got a complex patient coming to you, immediately it sets off alarm bells and that sets up the way that the whole process starts for them" (Focus group – Physiotherapist 5, p74).</p> <p>Labels which were reported to alert participants to potentially challenging or difficult service users included:  "Chronic pain. When I see that on a referral I often think that the potential of challenges being present ... is quite high" (Interview – Physiotherapist A, p74).</p> <p>Whether they've had mental health problems in the past ... You (also) think about things like head injuries for example and the unpredictability of that" (Interview – Physiotherapist C, p74).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>The authors suggest that these assumptions go unchallenged ‘... and thus the evaluation is perpetuated and shared, potentially affecting the therapeutic relationship’ (Authors p74).</p> <p>‘The 6-week model of intermediate care’ (p74)  The authors report that participants view their work as challenging when their goal of enabling service users to adapt to a sudden loss of function (both emotionally and physically) must be achieved within 6 weeks:</p> <p>“We get told to have someone rehabbed by a certain period or we have to manage our beds and the problem is we have to document a way of saying this patient is not compliant ... There’s ... always a ticking</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>clock” (Focus group – Physiotherapist 2, p74).</p> <p>‘The process of transition into the service’ (p74)  Participants are reported to have expressed frustration regarding the processes by which service users are referred and transferred into residential intermediate care</p> <p>“Some people just want to go home and don’t understand why they’ve been moved between wards in the hospital and now they’ve come to us completely disorientated ... and no one’s told them why they can’t go home they’ve just been sent to us”  (Interview – Physiotherapist D, p74).</p> <p>The authors highlight the role that the requirement for intermediate care services to meet local needs can play in creating inconsistent eligibility</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>criteria and delivery models which ultimately result in an unsettled transition period for service users.</p> <p>Some participants identified adequate communication of the rationale for transfer as key:            “If [the patients] are aware of what the service involves to begin with, that’s always quite a good start” (Focus group – Physiotherapist 5, p74).</p> <p>Coping strategies            The authors then go on to discuss the ‘coping strategies’ that participants felt were useful in cases where a service user had a ‘negative social evaluation’. These were collaborative goal setting, reflective practice and workforce planning.</p> <p>Workforce planning</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Participants are reported to have described a range of responsibilities within their teams and all are reported to have suggested that support was needed for practitioners working with service users with a 'negative social evaluation':</p> <p>“In our little team, we all have our own named patients and if we see that somebody is having a bad time, then (we) obviously talk with them and try and support them” (Interview – Physiotherapist D, p75).</p> <p>The authors suggest that participants had begun to develop emotional intelligence skills; the encouragement of which the authors suggest should be a priority for managers: “I try to be calm and if I feel I’m having a bad day (with patients), I’d speak to one of</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>my other colleagues to see whether they would see them. Because if you present a really negative picture, you're only going to transfer that onto the patient aren't you? And that's not beneficial" (Focus group – Physiotherapist 4, p75).</p> <p>Collaborative goal setting and patient engagement The authors report that participants regularly used collaborative goal setting to minimise the need to give a service user a 'negative social evaluation': "You sit down and (say) what are your goals, what have you got to do when you get home, what's your family (life) like, have you got grandkids, what do you do for them?" (Focus group – Physiotherapist 3, p75).</p> <p>Participants are reported to have viewed this</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>collaboration as ‘... a mechanism through which they can appraise their practice in light of the patient-centred ideology to which they subscribe. Increasingly, the physiotherapists wanted to negotiate the therapeutic intervention with the clients rather than enter into conflict’ (Authors, p75).</p> <p>Reflective practice Reflective practice was also reported to be a coping strategy used by participants:</p> <p>“I think it has quite an emotional impact on people so it’s important to discuss with MDT members and other agencies the best management for these clients and also reflecting on past cases” (Interview – Physiotherapist A, p75).</p>	

## Review question 2 – Critical appraisal tables – Effectiveness

1. Crotty M, Whitehead CH, Wundke R et al. (2005) Transitional care facility for elderly people in hospital awaiting a long term care bed: Randomised controlled trial. *British Medical Journal (Clinical Research Edition)* 331: 1110-3

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To ‘... assess the effectiveness of moving patients who are waiting in hospital for a long term care bed to an off-site transitional care facility’ (p1).</p> <p><b>Description of theoretical approach?</b> No. The authors do not provide a theory of change or logic model. It is simply implied that care for frail individuals who are medically stable but have high care needs can be provided in alternative facilities to a hospital.</p> <p><b>How was selection bias minimised?</b> Randomised. Computer generated in blocks of 12 stratified by referring hospital with a 2:1 allocation ratio (intervention: control).</p> <p><b>Was the allocation method concealed?</b> Yes. Allocation</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> No. Only 63% (n=134) of those allocated to the intervention were transferred to the facility and transfer did not take place for 78 individuals. The main reason for this was death or transfer to a long-term placement (n=29), and 5 participants were refused admission to the facility due to concerns regarding severe disruptive behaviour and need for additional staffing. A further 34% (n=15) declined to transfer at the second consent stage.</p> <p><b>Was contamination acceptably low?</b> Not reported.</p> <p><b>Did either group receive additional interventions or have services provided in a</b></p>	<p><b>Does the study’s research question match the review question?</b> Yes. The study aimed to ‘... assess the effectiveness of moving patients who are waiting in hospital for a long term care bed to an off-site transitional care facility’ (p1).</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. The study was approved by a number of ethics committees and participants provided written consent (proxy consent was given by the families of participants with dementia). Participants randomised to the intervention group were asked to consent for a second time after randomisation and before transfer to the facility.</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p>Due to the very short follow-up period of 4 months and the fact that a number of participants were not transferred to the intervention facility as intended it is not possible to award a higher quality rating to this study.</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall assessment of validity:</b> +</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>was concealed using sealed opaque envelopes).</p> <p><b>Were participants blinded?</b> Blinding not possible. Due to the nature of the intervention it would not have been possible to blind participants. In addition, the Zelen randomised consent process revealed group assignment to participants in the intervention group.</p> <p><b>Were providers blinded?</b> Blinding not possible. Due to the nature of the intervention it would not have been possible to blind participants.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Blind. Baseline assessments were conducted before randomisation and follow-up assessments were conducted by a research nurse blinded to group allocation.</p> <p><b>Did participants represent the target group?</b> Yes. An</p>	<p><b>different manner?</b> Not reported. There is no indication that either group received additional interventions or that services were provided in a different manner.</p> <p><b>Were outcomes relevant?</b> Yes.</p> <p><b>Were outcome measures reliable?</b> Yes. All outcome measures appear to have established reliability and validity however data to support this are not presented.</p> <p><b>Were all outcome measurements complete?</b> Yes. All data were measured and reported as planned, however 3 participants withdrew after randomisation and no data were available for these individuals.</p> <p><b>Were all important outcomes assessed?</b> Yes.</p>	<p><b>Were service users involved in the design of the study?</b> No. No indication that service users were involved in the design of the study or interpretation of findings.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study aims to evaluate the effectiveness of a transitional care facility providing multidisciplinary rehabilitation from a specialist elder care team.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. All participants were over the age of 18, however it should be noted that only participants for whom long-term care was deemed to be appropriate were eligible and the mean age of participants was 83 years.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>acceptable number of eligible individuals agreed to participate, however it should be noted that patients were only eligible if there was no long-term care bed available, discharge elsewhere had not already been arranged/the patient was assessed as ‘...unsuitable for other rehabilitation or community discharge support programmes ... (p1) and if no next of kin were available. It also appears that patients under the age of 65 were also ineligible (although this is not stated clearly). Individuals with dementia or behavioural problems <i>were</i> eligible unless it was thought that additional staff would be needed to provide care for them.</p> <p><b>Were all participants accounted for at study conclusion?</b> No. There was a high rate of attrition with 90 participants (28%) lost to follow-up. The reasons for this are</p>	<p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. Both groups were followed up for the same length of time, at 4 months.</p> <p><b>Was follow-up time meaningful?</b> Partly. Follow-up assessments were conducted at four-months which would only have been long enough to detect short-term effects of the intervention.</p> <p><b>Were the analytical methods appropriate?</b> Yes. t tests, Mann-Whitney U tests and <math>\chi^2</math></p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Yes. The authors state that the intervention and control groups were similar at baseline in relation to demographic characteristics, functional ability and quality of life;</p>	<p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. The intervention was provided in a transitional care facility, the control group received care in the hospital as usual and follow-up assessments were conducted in participant’s homes.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. The intervention consisted of transfer to a transitional care facility providing multidisciplinary rehabilitation from a specialist elder care team.</p> <p><b>(For effectiveness questions) Are the study outcomes relevant to the guideline?</b> Yes. Outcomes included quality of life, functional ability,</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>reported by the authors (all were due to death or withdrawal).</p>	<p>however significance testing is not reported.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Yes. The authors state that data were analysed according to random allocation.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Yes. The authors report that power calculations showed that 243 participants were needed to detect treatment effects at a significance level of 0.05 (90% power). n=320 participants were randomised.</p> <p><b>Were the estimates of effect size given or calculable?</b> Partly.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Partly. <i>p</i> values and confidence intervals are</p>	<p>readmissions to hospital, and care needs.</p> <p><b>(For views questions) Are the views and experiences reported relevant to the guideline?</b> N/A. No views and experiences data presented.</p> <p><b>Was the study conducted in the UK?</b> No. The study was conducted in Australia.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>provided in relation to some outcome measures but this is not consistent.</p> <p><b>Do conclusions match findings? Yes.</b></p>		

**2. Garåsen H, Windspoll R, Johnsen R (2007) Intermediate care at a community hospital as an alternative to prolonged general hospital care for elderly patients: A randomised controlled trial. BioMed Central Public Health 7: 68**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> The aim of the study was to compare the efficacy of intermediate care at a community hospital with standard prolonged care at a general hospital.</p> <p><b>Description of theoretical approach?</b> No. The authors do not outline a theoretical approach.</p> <p><b>How was selection bias minimised?</b> Randomised. Participants were randomised using random number tables in blocks to ensure balanced groups.</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Not reported. It does appear that the intervention/comparison went as planned.</p> <p><b>Was contamination acceptably low?</b> Yes. The comparison group did not receive the intervention and vice versa.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> Not</p>	<p><b>Does the study's research question match the review question?</b> Yes. The study's research question is in line with the review question.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. The study was approved by the Regional Committee for Medical Research Ethics for Central Norway.</p> <p><b>Were service users involved in the design of the study?</b> No. Service users were involved as participants only and not in the design of</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Was the allocation method concealed?</b> Not reported.</p> <p><b>Were participants blinded?</b> Blinding not possible.</p> <p><b>Were providers blinded?</b> Not reported.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Not reported.</p> <p><b>Did participants represent the target group?</b> Yes. Participants were recruited as intended and representative of the target group for this intervention.</p> <p><b>Were all participants accounted for at study conclusion?</b> Yes. There were no dropouts, except for deaths, although mortality was measured as 1 of the study's outcomes. 8 of the participants randomised for intervention were never transferred due to deterioration of their medical conditions after inclusion.</p>	<p>reported.</p> <p><b>Were outcomes relevant?</b> Yes. The study's outcome measures clearly relate to the outcomes which the authors wanted to impact.</p> <p><b>Were outcome measures reliable?</b> Yes. All outcome measures were objective. Data on readmissions was collected via patients' medical records and monitored through patient administrative systems, independent of treatment groups. Physical functioning was measured by specially trained nurses using a national system, Gerix.</p> <p><b>Were all outcome measurements complete?</b> Yes. All intended outcomes were measured and reported.</p> <p><b>Were all important outcomes assessed?</b> Partly. Although important outcomes were</p>	<p>the study or interpretation of results.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study clearly relates to intermediate care.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. The study population consists of older adults using intermediate care services.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. The study setting was intermediate care at a community hospital.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. The study relates to the efficacy of bed based intermediate care.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>assessed, participants' quality of life and satisfaction with the intervention may also have been useful to measure.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. Although not explicitly stated, participants were followed-up 6 months following discharge from intermediate care or care at the general hospital.</p> <p><b>Was follow-up time meaningful?</b> Partly. It may have been useful to follow-up participants 1 year following discharge from intermediate care or care at the general hospital in order to obtain the long term effects of the intervention.</p> <p><b>Were the analytical methods appropriate?</b> Yes. Differences in readmissions and need of home care services between groups were tested by chi square tests, and differences</p>	<p><b>(For effectiveness questions) Are the study outcomes relevant to the guideline?</b> Yes. Outcomes included number of readmissions, need of community home care and need of long-term nursing home.</p> <p><b>Was the study conducted in the UK?</b> No. The study was conducted in Norway.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>in mean number of days in institution were tested by paired t-test and by Wilcoxon signed rank test, adjusting for gender, age, activities of daily living score and diagnosis.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted? Yes.</b>  Participants randomised to intermediate care or to general hospital care were comparable with respect to number of days of care before randomisation, mean and median age, diagnosis, gender, physical functioning and matrimonial status.</p> <p><b>Was intention to treat (ITT) analysis conducted? Yes.</b> All participants, including the 8 that did not fully complete the intervention, were analysed in the groups to which they were originally allocated.</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Yes. A power calculation is presented. The final sample was sufficient to detect a difference.</p> <p><b>Were the estimates of effect size given or calculable?</b> No. Effect sizes are not provided.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Yes. Confidence intervals and <i>p</i> values are reported.</p> <p><b>Do conclusions match findings?</b> Yes. Conclusions are in line with findings, favouring intermediate care at a community hospital to standard prolonged care at a general hospital, with regards to better patient outcomes.</p>		

**3. Garåsen H, Windspoll R, Johnsen R (2008) Long-term patients' outcomes after intermediate care at a community hospital for elderly patients: 12-month follow-up of a randomized controlled trial. Scandinavian Journal of Public Health 36: 197-204**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> The aim of the study was to compare the efficacy of intermediate care at a community hospital with standard prolonged care at a general hospital.</p> <p><b>Description of theoretical approach?</b> No. There is no description of the theory behind the evaluated intervention.</p> <p><b>How was selection bias minimised?</b> Randomised. Participants were randomised using random number tables in blocks to ensure balanced groups.</p> <p><b>Was the allocation method concealed?</b> Not reported.</p> <p><b>Were participants blinded?</b> Blinding not possible.</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Not reported. It does appear that the intervention/comparison went as planned.</p> <p><b>Was contamination acceptably low?</b> Yes. The comparison group did not receive the intervention and vice versa.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> Not reported.</p> <p><b>Were outcomes relevant?</b> Yes. The study's outcome measures clearly relate to the outcomes which the authors wanted to impact.</p>	<p><b>Does the study's research question match the review question?</b> Yes. The study's research question clearly matches the review question.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. The study was approved by the Regional Committee for Medical Research Ethics for Central Norway.</p> <p><b>Were service users involved in the design of the study?</b> No. Service users were involved as participants only and not in the design of the study or interpretation of results.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study clearly relates to intermediate care.</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Were providers blinded?</b> Not reported.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Not reported.</p> <p><b>Did participants represent the target group?</b> Yes. Participants were recruited as intended and representative of the target group for this intervention.</p> <p><b>Were all participants accounted for at study conclusion?</b> Yes. During the follow-up time, about a quarter (24.6%) of the included patients died. NB. Eight of the participants randomised for intervention were never transferred due to deterioration of their medical conditions after inclusion.</p>	<p><b>Were outcome measures reliable?</b> Yes. Data were collected from participants' journals and health records. Number of days in institution, readmissions and deaths were also monitored through patient administrative systems, independent of treatment groups, to ensure that figures were correct.</p> <p><b>Were all outcome measurements complete?</b> Yes. All intended outcomes were measured and reported.</p> <p><b>Were all important outcomes assessed?</b> Partly. Although important outcomes were assessed, participants' quality of life and satisfaction with the intervention may also have been useful to measure.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. All data were collected were collected at discharge from</p>	<p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. The study population consists of older adults using intermediate care services.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. The study setting was intermediate care at a community hospital.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. The study relates to the efficacy of bed based intermediate care.</p> <p><b>(For effectiveness questions) Are the study outcomes relevant to the guideline?</b> Yes. The study's outcomes clearly relate to the overall topic of the guideline.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>community or general hospitals, and at 6 and 12 months from the time of inclusion.</p> <p><b>Was follow-up time meaningful?</b> Yes. Twelve months appeared sufficient to assess the benefits of the intervention and there were no dropouts during this time, except for deaths (n=35).</p> <p><b>Were the analytical methods appropriate?</b> Yes. Differences in readmissions and need of home care services between groups were tested by chi square tests, and differences in mean number of days in institution were tested by paired <i>t</i>-test and by Wilcoxon signed rank test, adjusting for gender, age, activities of daily living score and diagnosis.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Yes.</p>	<p><b>Was the study conducted in the UK?</b> No. The study was conducted in Norway.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>Participants randomised to intermediate care or to general hospital care were comparable with respect to number of days of care before randomisation, mean and median age, diagnosis, gender, physical functioning (activities of daily living) and matrimonial status.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Yes. All participants, including the 8 that did not fully complete the intervention, were analysed in the groups to which they were originally allocated.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Yes. A power calculation is presented. The final sample was sufficient to detect a difference.</p> <p><b>Were the estimates of effect size given or calculable?</b> Not reported. Effect sizes are not provided.</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Yes. Confidence intervals and p values are reported.</p> <p><b>Do conclusions match findings?</b> Yes. Conclusions are in line with findings, favouring intermediate care at a community hospital to standard prolonged care at a general hospital, with regards to better patient outcomes.</p>		

**4. Herfjord JK, Heggstad T, Erslund H et al. (2014) Intermediate care in nursing home after hospital admission: a randomized controlled trial with one year follow-up. BMC Research Notes 7: 889**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To evaluate the efficacy and safety of early transfer to an intermediate care unit in a nursing home. NB. It should be noted that this paper reports on the second phase of a randomised controlled trial (for which outcomes were changed).</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Yes. The authors state that ... the intervention was not modified during the course of the study' (p4).</p>	<p><b>Does the study's research question match the review question?</b> Yes. The paper reports the findings of the second phase of a trial designed to evaluate the efficacy and safety of early transfer to an intermediate care unit in a nursing home.</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p>Although the study appears to have been well carried out the decision to change the outcomes measured for the second phase of the study,</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Description of theoretical approach?</b> No. The authors do not provide a theory of change or a logic model; they simply note that earlier studies have shown that elderly patients can be treated successfully in 'step-down' facilities after a stay in hospital and that if it could be established that it was safe for this transfer to take place at an earlier point the '... service could be extended to a larger group of patients and have a greater impact in saving health care costs' (p3).</p> <p><b>How was selection bias minimised?</b> Randomised. Computer generated block randomisation.</p> <p><b>Was the allocation method concealed?</b> Yes.</p> <p><b>Were participants blinded?</b> Blinding not possible. Due to the nature of the intervention it would not have been possible to blind participants.</p>	<p><b>Was contamination acceptably low?</b> Partly. Contamination levels were low however it should be noted that 8 participants randomised to the intervention group had to remain in acute care (care as usual) due to medical concerns.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> No. There is no indication that either group received additional services.</p> <p><b>Were outcomes relevant?</b> Yes.</p> <p><b>Were outcome measures reliable?</b> Yes. All outcome data were extracted from medical records held at hospitals or with community health care services.</p> <p><b>Were all outcome measurements complete?</b></p>	<p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. Participants gave informed consent and a regional ethics committee gave approval for both the first and second phases.</p> <p><b>Were service users involved in the design of the study?</b> No. No indication that service users were involved in the design of the study or interpretation of findings.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study evaluates an intermediate care unit in a nursing home.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. All participants were over the</p>	<p>the fact that a small number of participants allocated to the intervention had to remain in acute care, and the post hoc decision to conduct subgroup analysis means that it is not possible to award a higher quality rating to this study.</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall assessment of validity:</b> +</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Were providers blinded?</b> Blinding not possible. Due to the nature of the intervention it would not have been possible to blind providers.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Blind.</p> <p><b>Did participants represent the target group?</b> Partly. The number of individuals assessed for eligibility was not recorded. Staff at the 2 hospitals from which participants were recruited were ‘... requested to consider every patient 70 year [sic] or older admitted from home’ (p5). Individuals were eligible if they were respiratory and circulatory stable, and viewed as being able to return to their home within 3 weeks. Exclusion criteria were – need for intensive care or surgery, and severe dementia or delirium. The authors note that patients with mild or moderate</p>	<p>Partly. All outcome data were measured and reported as planned however the study only reports on outcomes assessed as part of the second phase of the study. In addition, a number of subgroup analyses do not appear to have been reported.</p> <p><b>Were all important outcomes assessed?</b> Partly. The paper only reports on outcome data collected in the second phase of the study which were number of days living at home or in a nursing home, the number of days in hospital, mortality at 1 year, and use of home health care. Service user level outcomes such as functional ability and quality of life were collected during the first phase of the trial but due to low response rates and other information which was ‘indeterminate’, the ‘... investigators were on the whole unable to draw any decisive conclusions’ (p2). The</p>	<p>age of 18, however the youngest of these was 70.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. The intervention was delivered in an inpatient intermediate care unit established in a nursing home.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. The study evaluates an inpatient intermediate care intervention.</p> <p><b>(For effectiveness questions) Are the study outcomes relevant to the guideline?</b> Yes. Outcome measures included number of days living at home or in a nursing home, the number of days in hospital, mortality at one year, and use of home health care.</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>dementia were eligible. Details in relation to ethnicity, socio-economic status, etc. are not reported.</p> <p><b>Were all participants accounted for at study conclusion?</b> Yes. There were no participants who were lost to follow-up.</p>	<p>findings of the first phase are only available in a Norwegian language article.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. Both groups were followed up for the same amount of time.</p> <p><b>Was follow-up time meaningful?</b> Partly. Participants were followed up for 1 year (post randomisation) in total which would allow short and intermediate term effects to be detected.</p> <p><b>Were the analytical methods appropriate?</b> Yes. Methods included Mann-Whitney U-test, chi-square, Kaplan-Meier, etc. Observations made during the trial suggested that outcomes differed according to patient classification (medical or orthopaedic) and a post-hoc subgroup analysis was conducted to investigate this. Patient classification details</p>	<p><b>(For views questions) Are the views and experiences reported relevant to the guideline?</b> N/A. No views and experiences data presented.</p> <p><b>Was the study conducted in the UK?</b> No. The study was conducted in Norway.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>were extracted from hospital discharge notes, which the authors report use ICD-10 definitions as the basis for classification.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Not reported. The authors do not report significance testing of baseline characteristics except in relation to use of home health care services, which did not differ significantly by group (p=0.47).</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Yes.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Yes. Power calculations for the first phase of the study showed that to detect an improvement of 10% or more in functional ability with 80% power at a</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>significance level of 0.05 (allowing for a drop-out rate of 30%) 400 participants were required. Four hundred participants were randomised and 376 were included in analyses.</p> <p><b>Were the estimates of effect size given or calculable?</b> Yes.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Yes. p values and confidence intervals are provided.</p> <p><b>Do conclusions match findings?</b> Yes.</p>		

**5. Kalra L, Evans A, Perez I et al. (2005) A randomised controlled comparison of alternative strategies in stroke care. Health Technology Assessment 9: 18**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To compare a range of outcomes at 3, 6 and 12 months between stroke patients managed on the stroke unit, on</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Yes.</p>	<p><b>Does the study's research question match the review question?</b> Yes. Management of stroke patients in a stroke</p>	<p><b>Overall assessment of internal validity:</b> ++</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>general wards with stroke team support or at home by specialist domiciliary care team.</p> <p><b>Description of theoretical approach?</b> Partly.</p> <p><b>How was selection bias minimised?</b> Randomised. Randomisation was unstratified using the block randomisation technique, in 16 blocks of 30.</p> <p><b>Was the allocation method concealed?</b> Yes. Randomisation was conducted in an office remote from patient treatment areas, so that it would not be possible for those enrolling patients to guess allocation for the vast majority of subjects.</p> <p><b>Were participants blinded?</b> Blinding not possible.</p> <p><b>Were providers blinded?</b> Not reported.</p>	<p><b>Was contamination acceptably low?</b> Not reported.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> Not reported.</p> <p><b>Were outcomes relevant?</b> Yes.</p> <p><b>Were outcome measures reliable?</b> Yes.</p> <p><b>Were all outcome measurements complete?</b> Yes.</p> <p><b>Were all important outcomes assessed?</b> Yes.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. At 3, 6 and 12 months.</p>	<p>unit, on general wards with stroke team support or at home by specialist domiciliary care team.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. The project was approved by the local ethics committee.</p> <p><b>Were service users involved in the design of the study?</b> No.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes.</p> <p><b>Does the study relate to at least one of the activities</b></p>	<p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> ++</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Blind. Independent observers were used for assessment and using outcome measures.</p> <p><b>Did participants represent the target group?</b> Yes.</p> <p><b>Were all participants accounted for at study conclusion?</b> Yes. Nine drop-outs in home group; 3 in stroke team group.</p>	<p><b>Was follow-up time meaningful?</b> Yes.</p> <p><b>Were the analytical methods appropriate?</b> Yes. Descriptive.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Yes. Baseline characteristics well matched across the 3 groups in stroke type and severity, level of impairment and initial disability.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Yes.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Yes. Power calculation conducted as part of design.</p>	<p><b>covered by the guideline?</b> Yes. Bed based vs. home based care.</p> <p><b>(For effectiveness questions) Are the study outcomes relevant to the guideline?</b> Yes.</p> <p><b>Was the study conducted in the UK?</b> Yes. The study was conducted in Bromley, south east England.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Were the estimates of effect size given or calculable?</b> Yes.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Yes.</p> <p><b>Do conclusions match findings?</b> Yes.</p>		

**6. Stenvall M, Olofsson B, Nyberg L et al. (2007) Improved performance in activities of daily living and mobility after a multidisciplinary postoperative rehabilitation in older people with femoral neck fracture: A randomized controlled trial with 1-year follow-up. Journal of Rehabilitation Medicine 39: 232-8**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> The aim of the study was to investigate the short and long-term effects of a multidisciplinary postoperative rehabilitation programme in patients with femoral neck fracture.</p> <p><b>Description of theoretical approach?</b> No. There is no description of the theory behind the evaluated intervention.</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Not reported. It does appear that the intervention/comparison went as planned.</p> <p><b>Was contamination acceptably low?</b> Not reported.</p> <p><b>Did either group receive additional interventions or</b></p>	<p><b>Does the study's research question match the review question?</b> Yes. The study's research question clearly matches the review question: to investigate the short- and long-term effects of a multidisciplinary postoperative rehabilitation programme among patients with femoral neck fracture regarding living conditions,</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> +</p> <p><b>Overall validity rating:</b> +</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>How was selection bias minimised?</b> Randomised. Method of randomisation not reported, but it was stratified according to the operation methods used based on the degree of hip dislocation.</p> <p><b>Was the allocation method concealed?</b> Yes. Allocation lots were numbered sequentially, placed in opaque sealed envelopes. Envelopes not opened till immediately before surgery to ensure all receive similar pre-op treatment. The selection procedures were carried out by people not involved in the study.</p> <p><b>Were participants blinded?</b> Blinding not possible.</p> <p><b>Were providers blinded?</b> Blinding not possible.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Not blind. The outcomes analyst was blind - a</p>	<p><b>have services provided in a different manner?</b> Not reported.</p> <p><b>Were outcomes relevant?</b> Yes. The study's outcome measures clearly relate to the outcomes which the authors wanted to impact.</p> <p><b>Were outcome measures reliable?</b> Yes. Outcomes were measured using a variety of validated questionnaires. These were observed rather than self-reported.</p> <p><b>Were all outcome measurements complete?</b> Yes. All intended outcomes were measured and reported.</p> <p><b>Were all important outcomes assessed?</b> Partly. Although important outcomes were assessed, quality of life and satisfaction with the intervention may also have</p>	<p>walking ability and activities of daily living performance. A secondary aim was to investigate outpatient rehabilitation consumption and inpatient days after discharge and mortality.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. The study was approved by the ethics committee of the Faculty of Medicine at Umeå University. Patients asked in writing and orally if they were willing to participate in study, and were told they could withdraw participation at any time during the study.</p> <p><b>Were service users involved in the design of the study?</b> No. Service users were involved as participants only and not in the design of the study or interpretation of results.</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>geriatrician, who was unaware of the study group allocation, analysed all assessments and documentations after the study was finished.</p> <p><b>Did participants represent the target group?</b> Yes. Participants were recruited as intended and representative of the target group for this intervention i.e. patients involved in a multidisciplinary postoperative rehabilitation programme.</p> <p><b>Were all participants accounted for at study conclusion?</b> Yes. The attrition rate was approximately 20%. Reasons given for all dropout included death or withdrawal from study, however, all participants (n=199) were included in the primary analysis but 82% (84/102) of the intervention group and 78% (76/97) of the control group were analysed at 12 months follow-up.</p>	<p>been useful for the authors to consider.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. Both groups had similar follow-up times at 4 and 12 months.</p> <p><b>Was follow-up time meaningful?</b> Yes. Follow-up time appeared long enough to assess the impact of the intervention and attrition rate was acceptably low.</p> <p><b>Were the analytical methods appropriate?</b> Yes. The analytical methods were appropriate for this type of data, using Student's <i>t</i>-test, Pearson's <math>\chi^2</math> test and the Mann-Whitney U test to analyse group differences, and odds ratios and confidence intervals analysed by logistic regression.</p>	<p><b>Is there a clear focus on the guideline topic?</b> Yes. The study relates to the overall topic of the guideline.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. The study population consists of older adults using intermediate care services.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. The study setting was a geriatric unit intervention ward.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. It examines 'effects of a multidisciplinary postoperative rehabilitation programme among patients with femoral neck fracture' in a geriatric ward.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Yes. Both groups were similar at baseline except for 'diagnosed depression' and 'on anti-depressants' (significantly higher in control group). These differences were adjusted for in the analysis.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> No.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Not reported.</p> <p><b>Were the estimates of effect size given or calculable?</b> Yes. Odds ratios are reported.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Yes. Confidence intervals are reported.</p>	<p><b>(For effectiveness questions) Are the study outcomes relevant to the guideline?</b> Yes. The study's outcomes relate to the overall topic of the guideline.</p> <p><b>Was the study conducted in the UK?</b> No. The study was conducted in Sweden.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Do conclusions match findings?</b> Yes. The authors overall conclusions match the findings presented.</p>		

**7. Young J, Green J, Forster A et al. (2007) Postacute care for older people in community hospitals: A multicenter randomized, controlled trial. Journal of the American Geriatrics Society 55: 1995-2002**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> The study aims to ‘... compare the effects of community hospital care on independence for older people needing rehabilitation with that of general hospital care’ (p1995). The authors hypothesise that elderly patients transferred to community hospital care would achieve greater independence than those treated in elderly care departments.</p> <p><b>Description of theoretical approach?</b> No. The authors do not provide a theory of change or logic model.</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Not reported. The authors do not provide detail in relation to exposure.</p> <p><b>Was contamination acceptably low?</b> No. The authors do not clearly report levels of contamination. It appears that 39 participants randomised to the intervention group did not receive care as intended (due to a lack of available beds in community hospitals or the closure of local community hospitals); however the authors do not clearly state what care these participants received instead. Similarly,</p>	<p><b>Does the study’s research question match the review question?</b> Yes. The study aims to ‘... compare the effects of community hospital care on independence for older people needing rehabilitation with that of general hospital care’ (p1995). The authors note that community hospitals represent “... 1 type of intermediate care service model ...” (p1999). They hypothesise that elderly patients transferred to community hospital care would achieve greater independence than those</p>	<p><b>Overall assessment of internal validity:</b> -</p> <p>Due to the high number of eligible patients who did not participate; high rates of attrition; a relatively high number of control group participants who were transferred to a study community hospital rather than receiving care as usual, or after receiving care as usual were then transferred to non-participating community hospitals, intermediate care facilities or rehabilitation facilities; and blinding concerns it is not</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>How was selection bias minimised?</b> Randomised. Randomisation was stratified on the basis of referral centre, cognitive impairment, and functional ability. Ratios for randomisation were pre-specified on the basis local bed availability.</p> <p><b>Was the allocation method concealed?</b> Yes.</p> <p><b>Were participants blinded?</b> Blinding not possible. Due to the nature of the intervention it would not have been possible to blind participants.</p> <p><b>Were providers blinded?</b> Blinding not possible. Due to the nature of the intervention it would not have been possible to blind providers.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Part blind. It appears that at the final follow-up assessment a number of</p>	<p>although the control intervention 'primarily' consisted of '... an extended general hospital stay with multidisciplinary care ...' patients could be transferred to '... other postacute services according to existing local operational policies' (p1997). It appears that 30 participants randomised to the control group were actually transferred to a community hospital and that of the 180 who did at first remain in general hospital; 11 were later transferred to a non-participating community hospital; 3 to a rehabilitation unit; 2 to an intermediate care placement whilst waiting for home care 'places' (not clear if this actually refers to a care home placement), and 1 was admitted to a psychiatric unit.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> Not reported. There is no indication</p>	<p>treated in elderly care departments.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. The trial was approved by regional and multicentre ethics committees, and written consent was provided by participants (or their proxy if capacity was a concern).</p> <p><b>Were service users involved in the design of the study?</b> No. No indication that service users were involved in the design of the study or interpretation of findings.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study evaluates community hospital care which the authors categorise as a specific type of intermediate care service model.</p>	<p>possible to award a higher quality rating to this study.</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall assessment of validity:</b> +</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>participants revealed group assignment to outcome assessors who were then able to guess the group assignment for other participants, however the authors determined that an acceptable level of blinding was still achieved: 'At the 6-month assessment, 63 patients or caregivers unintentionally unblinded outcome assessors to treatment allocation, who correctly guessed the allocation of 143 (56.1%) of the remaining 255 patients at the 6-month assessment (missing data for 15 patients), resulting in a kappa statistic of &lt;0.20 (poor agreement), indicating that reasonable masking of treatment allocation was achieved' (p1998). It is also unclear if researchers who collected data from patient records were blinded to group assignment.</p> <p><b>Did participants represent the target group?</b> Partly. Out of 773 patients deemed to be</p>	<p>that either group received care in addition to the intervention/control or had services provided in a different manner.</p> <p><b>Were outcomes relevant?</b> Yes. The researchers were primarily interested in the effects of the intervention on older people's independence and outcome measures were appropriate to this.</p> <p><b>Were outcome measures reliable?</b> Yes. All outcome measures appear to have established reliability and validity however data to support this are not presented. It should also be noted that the scale used to measure satisfaction with services appears to be specific to stroke care.</p> <p><b>Were all outcome measurements complete?</b> Yes. All data were measured and collected as planned</p>	<p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. All participants were over the age of 18 however the majority were elderly.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. The interventions were delivered in community and general hospitals.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. The study evaluates multidisciplinary care provided in a community hospital which is considered by the authors to be one of a number of intermediate care service models.</p> <p><b>(For effectiveness questions) Are the study outcomes relevant to the</b></p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>eligible, 144 did not consent to participation, and staff at referral sites refused to allow a further 136 patients to be randomised. Staff rationale for this is not reported. Individuals were eligible if they had been admitted to an elderly care or combined elderly care and medical unit after an emergency. Individuals had to be deemed to be medically stable and in need of postacute rehabilitation (in advance of expected home discharge) by a physician. Patients were also excluded if they were drowsy or unconscious; were in need of specialist stroke rehabilitation, treatment in other departments, or surgery; or were in need of a new residential or nursing home placement. An address in the catchment area of 1 of the participating hospitals was also required. Details in relation to ethnicity, socio-economic status, etc. are not reported but the authors report that the majority of participants were females</p>	<p>however data appear to be missing for a number of participants at various follow-up points in relation to a range of different measures and it is not clear how the authors dealt with this missing data. In addition it should be noted that statistical analysis of between group differences are only reported for certain outcomes at a small number of time points and it is not clear from the narrative whether any of these showed significant between group differences.</p> <p><b>Were all important outcomes assessed?</b> Partly. It is disappointing that readmissions to acute care were not measured.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. Both groups were followed up for the same length of time.</p>	<p><b>guideline?</b> Yes. Outcomes included activities of daily living, health status, anxiety and depression.</p> <p><b>(For views questions) Are the views and experiences reported relevant to the guideline?</b> N/A. Not views question. However, data relating to a quantitative measure of service satisfaction is reported.</p> <p><b>Was the study conducted in the UK?</b> Yes. The study was conducted across a number of sites in the midlands and the north of England.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>over the age of 80 who lived on their own.</p> <p><b>Were all participants accounted for at study conclusion?</b> No. There was a high rate of attrition and by the first follow-up (one week after discharge) only 394 participants out of the 490 randomised completed assessments. At 3 months (post-randomisation) only 365 participants completed assessments, and at 6 months (post-randomisation) only 333 participants completed assessments. Explanations for loss to follow-up are provided which were all due to death or withdrawal. Higher numbers of participants were lost to follow-up in the intervention group than the control group however significance testing is not reported in relation to this.</p>	<p><b>Was follow-up time meaningful?</b> Partly. The final follow-up assessment took place at 6 months which would not allow longer-term effects to be detected.</p> <p><b>Were the analytical methods appropriate?</b> Yes. Included analysis of covariance, Mann-Whitney U-Test and <math>\chi^2</math>. All analyses were pre-specified however statistical analysis of between group differences is only reported for a very small number of secondary outcomes.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Yes. The authors state that characteristics of the 2 groups were similar at baseline however significance testing is not reported and it should be noted that very little information in relation to</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>demographic characteristics are reported.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Partly. The authors' report that intention to treat analysis was conducted for the primary outcome measure however they do not state whether all other analyses were conducted on this basis.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Yes. The authors report that power calculations using a standard deviation of 5.3 for within patient changes and a clinically meaningful difference of 2 points on the primary outcome measure (Nottingham Extended Activities of Daily Living scale) showed that a sample size of 250-400 was required to detect differences at 85% power at a 5% and 1% significance respectively. The authors</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>aimed to recruit 500 patients to allow for attrition and a total of 490 were randomised.</p> <p><b>Were the estimates of effect size given or calculable?</b> Partly.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Partly. Confidence intervals and <i>p</i> values are provided however this is not consistent.</p> <p><b>Do conclusions match findings?</b> Yes.</p>		

## Review question 2 – Critical appraisal – the views and experiences of people using services, their families and carers

### 1. Ariss S (2014) National audit for intermediate care: Patient reported experiences, 2014. Sheffield: University of Sheffield

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<b>Study aim:</b> To obtain views and experiences from people using intermediate care by asking the following survey question: 'Do	<b>Basic data adequately described?</b> Partly. More data on the numbers/ proportions	<b>Does the study's research question match the review question?</b> Yes. The survey, which was part of the NAIC	<b>Overall assessment of internal validity:</b> -

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>you feel that there is something that could have made your experience of the service better?’</p> <p><b>Objectives of the study clearly stated?</b> Partly. The objective is simply to answer the one survey question.</p> <p><b>Research design clearly specified and appropriate?</b> Partly. It is not clear exactly how the survey was conducted but details of the methods of analysis are provided.</p> <p><b>Clear description of context?</b> Partly. The context of the survey is clear but we do not have details about the context of the survey respondents (except that they have used bed based intermediate care).</p> <p><b>References made to original work if existing tool used?</b> N/A.</p>	<p>making certain responses could have been provided.</p> <p><b>Results presented clearly, objectively and in enough detail for readers to make personal judgements?</b> Partly.</p> <p><b>Results internally consistent?</b> Partly. On the whole, yes although numbers weren't routinely provided against responses.</p> <p><b>Data suitable for analysis?</b> Yes.</p> <p><b>Clear description of data collection methods and analysis?</b> Partly. Clear description of data analysis but not data collection.</p> <p><b>Methods appropriate for the data?</b> Yes.</p> <p><b>Statistics correctly performed and interpreted?</b> Partly. In terms of statistics,</p>	<p>2014, asked the question ‘Do you feel that there is something that could have made your experience of the service better?’ Yes or no, and then a space to provide further information. The question was asked to people using bed based, and home based intermediate care and reablement.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> No. There is no discussion of ethical issues or ethical approval for the survey.</p> <p><b>Were service users involved in the study?</b> No.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes.</p>	<p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> -</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p><b>Reliability and validity of new tool reported?</b> Unclear. No information about the validity and reliability of the single survey question, why it was chosen or worded the way it was.</p> <p><b>Survey population and sample frame clearly described?</b> No. We only know that the sampling frame is people using bed based intermediate care in England.</p> <p><b>Representativeness of sample is described?</b> No. We have no idea how representative the sample is.</p> <p><b>Subject of study represents full spectrum of population of interest?</b> Unclear. The author does not provide any information that would help us judge whether the study represents the full spectrum of the population of interest.</p>	<p>only frequencies were produced and even then, not for all the themes, which means we don't know how many respondents cited each issue - this could have been provided in the ranked table. Further statistical analyses could have been usefully produced, e.g. cross tabulations or, if the data had been collected, responses could have been linked with service users' characteristics.</p> <p><b>Response rate calculation provided?</b> No.</p> <p><b>Methods for handling missing data described?</b> No.</p> <p><b>Difference between non-respondents and respondents described?</b> No.</p> <p><b>Results discussed in relation to existing knowledge on subject and study objectives?</b> No.</p>	<p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes.</p> <p><b>(For views questions) Are the views and experiences reported relevant to the guideline?</b> Yes.</p> <p><b>Does the study have a UK perspective?</b> Yes. The National Audit of Intermediate Care, focuses on intermediate care commissioning and provision in England.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study large enough to achieve its objectives, sample size estimates performed?</b> No. No evidence that sample size estimates have been made.</p> <p><b>All subjects accounted for?</b> No. The paper does not provide a figure for the total number of people who received the survey.</p> <p><b>Measures for contacting non-responders?</b> No. No evidence that non responders were followed up.</p> <p><b>All appropriate outcomes considered?</b> N/A. No outcomes were measured, the survey simply comprised of 1 open ended question.</p>	<p><b>Limitations of the study stated?</b> No.</p> <p><b>Results can be generalised?</b> Unclear. No information provided regarding respondents.</p> <p><b>Appropriate attempts made to establish 'reliability' and 'validity' of analysis?</b> No.</p> <p><b>Conclusions justified?</b> Unclear. No conclusions are provided in this paper.</p>		

**2. Benten J and Spalding N (2008) Intermediate care: What are service users' experiences of rehabilitation? Quality in Ageing and Older Adults 9:4-14.**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> The researchers aimed to '...explore service users' experiences of a 22-bedded intermediate care</p>	<p><b>Is the context clearly described?</b> Clear. The authors provide a good level of detail in relation to participant</p>	<p><b>Does the study's research question match the review question?</b> Yes. The researchers aimed to</p>	<p><b>Overall assessment of internal validity:</b> +</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>service' (p4). Out of 6 themes that emerged from this research, this paper presents findings with the in relation to one and the specific question – '... did the intermediate care unit provide rehabilitation that met the needs of service users?' (p5).</p> <p><b>Is a qualitative approach appropriate?</b> Appropriate. The researchers aimed to explore service user experience.</p> <p><b>Is the study clear in what it seeks to do?</b> Clear. The research objectives are clearly expressed and there is a good discussion of the policy context for intermediate care. Although the authors do not really make reference to existing literature on the subject of intermediate care they do note the importance of research with service users and emphasise the role that this can play in improving health care services.</p>	<p>characteristics and the setting in which data collection took place and they clearly considered the issue of context bias.</p> <p><b>Was the sampling carried out in an appropriate way?</b> Somewhat appropriate. The authors report the use of purposive sampling which is appropriate however they also note that this was conducted using quite specific eligibility criteria (rather than anyone with experience of the facility). For example, only participants over the age of 65 and those who had stayed at the facility for a minimum of 2 weeks were eligible, etc.; meaning that younger service users and those with very short stays could not have been interviewed. In addition it should be noted that the authors do not discuss the process by which they came to select the facility at which participants were recruited or</p>	<p>'...explore service users' experiences of a 22-bedded intermediate care service' (p4). Out of 6 themes that emerged from this research, this paper presents findings relating to 1 of these themes and specifically focuses on the research question – '... did the intermediate care unit provide rehabilitation that met the needs of service users?' (p5).</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. A regional NHS research ethics committee approved the study and participants provided informed consent.</p> <p><b>Were service users involved in the study?</b> No. Service users involved as participants only. No indication of involvement in design of study or interpretation of findings.</p>	<p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p><b>How defensible/rigorous is the research design/methodology?</b> Somewhat defensible. The authors provide a relatively clear rationale for their chosen data collection and analysis techniques. Although they also provide a clear report of their participant sampling strategy (purposive) they do not discuss how they selected the facility at which participants were recruited.</p> <p><b>How well was the data collection carried out?</b> Somewhat appropriately. Data collection methods are clearly described and appropriate to the research question, however no details are provided in relation data management or record-keeping.</p>	<p>whether this facility itself had any eligibility criteria.</p> <p><b>Were the methods reliable?</b> Somewhat reliable. Data were only collected via semi-structured interview however a reasonably adequate discussion of the findings in relation to other research is included.</p> <p><b>Are the data 'rich'?</b> Mixed. The contexts of the data are described (the interview schedule is included as an appendix) and the depth and detail of the data are demonstrated however responses were not really compared and contrasted.</p> <p><b>Is the analysis reliable?</b> Reliable. The researchers reviewed each other's coding and a practitioner with research experience was also involved in this process to ensure that data was interpreted appropriately;</p>	<p><b>Is there a clear focus on the guideline topic?</b> Yes. The study reports service user experiences of an intermediate care unit. However it should be noted that this paper only reports findings in relation to 1 theme that emerged from the research – service users' experience of rehabilitation in the intermediate care facility.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. All participants were over the age of 18 however it should be noted that the youngest was 64 years of age.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes.</p> <p><b>(For views questions) Are the views and experiences reported relevant to the</b></p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>however the authors do not report how discrepancies or disagreements were dealt with. Participants also appear to have been able to provide feedback on transcripts of interviews although this does not appear to be the case for the coding or reporting stage.</p> <p><b>Are the findings convincing?</b> Convincing. The findings are clear and coherent and an appropriate number of adequately referenced quotes are included.</p> <p><b>Are the conclusions adequate?</b> Adequate. The conclusions are generally plausible and coherent with relatively clear links to the data.</p>	<p><b>guideline?</b> Yes. The study reports service user views of an intermediate care facility.</p> <p><b>Was the study conducted in the UK?</b> Yes.</p>	

## Review question 2 – Critical appraisal – Health, social care and other practitioners’ views and experiences

### 1. Millar AN, Hughes CM, Ryan C (2015) ‘It’s very complicated’: A qualitative study of medicines management in intermediate care facilities in Northern Ireland. Biomed Central Health Services Research 15: 216

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> The study aimed to explore healthcare workers' and patients' views and attitudes towards medicines management services in intermediate care facilities in Northern Ireland.</p> <p><b>Is a qualitative approach appropriate?</b> Appropriate. A qualitative approach is appropriate to address the research questions proposed.</p> <p><b>Is the study clear in what it seeks to do?</b> Clear. The aims and objectives of the study are clearly outlined, and reference to the relevant literature is made throughout.</p> <p><b>How defensible/rigorous is the research design/methodology?</b> Defensible. The authors provide</p>	<p><b>Is the context clearly described?</b> Unclear. The authors do not specify where interviews were conducted.</p> <p><b>Was the sampling carried out in an appropriate way?</b> Somewhat appropriate. Participation in the study was voluntary, therefore, it is possible that the views and experiences expressed reflected those with an interest in medicines management.</p> <p><b>Were the methods reliable?</b> Somewhat reliable. The data was not collected by more than 1 method, but the authors did triangulate the data and discuss their findings alongside other studies.</p>	<p><b>Does the study’s research question match the review question?</b> Yes. The study's research question clearly matches the review question.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. The study was approved by the Office for Research Ethics Committees Northern Ireland.</p> <p><b>Were service users involved in the study?</b> No. Service users were involved as participants only, and not in the design of the study or interpretation of results.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study clearly relates to the overall topic of the guideline.</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>a clear rationale for the sampling, data collection and data analysis techniques used.</p> <p><b>How well was the data collection carried out?</b> Appropriately. The data collection methods are clearly described and seem appropriate to address the research question.</p>	<p><b>Are the data 'rich'?</b> Rich. The contexts of the data are clearly described, and include the perspectives of both health care workers and patients. Responses are also compared/contrasted across settings.</p> <p><b>Is the analysis reliable?</b> Reliable. More than 1 researcher themed and coded the data, and consensus on emergent themes was reached by discussion among all 3 researchers. It is clear how the themes and concepts were derived from the data, and the researchers use quotes to illustrate how they developed the analysis.</p> <p><b>Are the findings convincing?</b> Convincing. The findings are clearly presented and internally coherent in that they address the study question. Extracts from the original data are included and the data is</p>	<p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. The study population clearly relates to the guideline scope.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. The study setting clearly relates to the guideline scope.</p> <p><b>(For views questions) Are the views and experiences reported relevant to the guideline?</b> Yes. The views and experiences reported in the study are clearly relevant to the guideline topic.</p> <p><b>Does the study have a UK perspective?</b> Yes. The study was conducted in Northern Ireland.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>appropriately referenced. The reporting is clear and coherent.</p> <p><b>Are the conclusions adequate?</b>  Adequate. There are clear links between the data, interpretation and conclusions, which are plausible and coherent. Alternative explanations have also been explored. Implications of the research are clearly defined and there is adequate discussion of the limitations of the study.</p>		

**2. Regen E, Martin G, Glasby J et al. (2008) Challenges, benefits and weaknesses of intermediate care: Results from five UK case study sites. Health & Social Care in the Community 16: 629–37**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> The research was designed to ‘... explore the views of practitioners and managers on the implementation of intermediate care for elderly people across England, including their perceptions of the challenges involved in its implementation,</p>	<p><b>Is the context clearly described?</b> Not sure. The authors provide a good level of detail in relation to the sites at which participants worked, however very little detail is provided in relation to the demographic characteristics and professional background</p>	<p><b>Does the study’s research question match the review question?</b> Partly. The research was designed to ‘... explore the views of practitioners and managers on the implementation of intermediate care for elderly people across England,</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b></p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>and their assessment of the main benefits and weaknesses of provision' (p629).</p> <p><b>Is a qualitative approach appropriate?</b> Yes. The researchers aimed to explore the views of practitioners and managers regarding the implementation and benefits and weaknesses of intermediate care.</p> <p><b>Is the study clear in what it seeks to do?</b> Clear. The research objectives are clearly expressed and there is a good discussion regarding the policy context of intermediate care and the wider literature on this service.</p> <p><b>How defensible/rigorous is the research design/methodology?</b> Somewhat defensible. The authors provide a relatively clear rationale for their chosen sampling, data collection and data analysis techniques;</p>	<p>of participants. An appropriate level of detail is provided in relation to the settings in which data collection took place, however the authors do not specifically discuss the issue of context bias. It should also be noted that it is sometimes difficult to determine whether participants are referring to bed based intermediate care specifically.</p> <p><b>Was the sampling carried out in an appropriate way?</b> Somewhat appropriate. The authors report that they relied on contacts at each site to identify potential interviewees and that although they emphasised that they sought to incorporate a range of perspectives, the majority of participants were directly involved in the provision of care or management of services.</p> <p><b>Were the methods reliable?</b></p>	<p>including their perceptions of the challenges involved in its implementation, and their assessment of the main benefits and weaknesses of provision' (p629).</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Partly. An ethics committee approved the research however no details are provided in relation to consent processes.</p> <p><b>Were service users involved in the study?</b> No. No indication that service users were involved in design of the study or interpretation of findings.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study focuses on intermediate care delivered across 5 sites in the United Kingdom.</p>	<p>+</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>however this is not very detailed.</p> <p><b>How well was the data collection carried out?</b> Appropriately. The data collection methods are appropriate to the research question, and a good level of detail is provided in relation to this, however there are no details relating to data management or record-keeping.</p>	<p>Reliable. Data were triangulated.</p> <p><b>Are the data 'rich'?</b> Mixed. The authors do not provide a great deal of detail in relation to the contexts of the data. Although there is a good sense of the detail and depth of data, there is no comparative element.</p> <p><b>Is the analysis reliable?</b> Somewhat reliable. Data do not appear to have been analysed or coded by more than 1 researcher however the research team met regularly to discuss themes and concepts that were emerging and discrepant results appear to have been used to modify themes where necessary. The authors also report that participants and funders were given opportunities to feedback on the results but it is not clear how this was carried out.</p>	<p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. Practitioners and managers working in intermediate care services.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes.</p> <p><b>(For views questions) Are the views and experiences reported relevant to the guideline?</b> Yes. The study reports the views of practitioners and managers regarding intermediate care.</p> <p><b>Was the study conducted in the UK?</b> Yes. The study was conducted across 5 sites in England.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Are the findings convincing?</b> Convincing. The findings are clearly and coherently presented and an appropriate number of adequately referenced quotes are included.</p> <p><b>Are the conclusions adequate?</b> Somewhat adequate. Although the conclusions are plausible and coherent, the links between these conclusions and the data are somewhat unclear.</p>		

**3. Thomson D and Love H (2013) Exploring the negative social evaluation of patients by specialist physiotherapists working in residential intermediate care. Physiotherapy 99: 71-7**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> The researchers aimed to ‘... gain an understanding of the negative social evaluation of patients by specialist physiotherapists, and to explore possible coping strategies in order to engage patients in appropriately designed rehabilitation programmes’ (p71). The authors</p>	<p><b>Is the context clearly described?</b> Not sure. The authors provide a good level of detail in relation to the professional background of participants, however very little detail is provided in relation to demographic characteristics of participants, or to the settings in which data collection took</p>	<p><b>Does the study’s research question match the review question?</b> Partly. The researchers aimed to ‘... gain an understanding of the negative social evaluation of patients by specialist physiotherapists, and to explore possible coping strategies in order to engage</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>go on to explain that ‘negative social evaluation’ is a more acceptable term than ‘difficult’ in relation to service users who represent an ‘interpersonal’ challenge to practitioners. These practitioners were working at a residential intermediate care facility.</p> <p><b>Is a qualitative approach appropriate?</b> Yes. The researchers aimed to develop an understanding of why physiotherapists may perceive some service users as having a ‘negative social evaluation’, as well as the strategies which were used when working with such service users.</p> <p><b>Is the study clear in what it seeks to do?</b> Clear. The research objectives are clearly expressed and there is a good discussion of the wider literature.</p> <p><b>How defensible/rigorous is the research</b></p>	<p>place (e.g. number or length of focus groups/interviews), and the issue of context bias is not specifically discussed by the authors.</p> <p><b>Was the sampling carried out in an appropriate way?</b> Somewhat appropriate. The authors report the use of purposeful and then theoretical sampling, which are appropriate however it is not clear why only senior physiotherapists took part in the research.</p> <p><b>Were the methods reliable?</b> Reliable. Data were triangulated.</p> <p><b>Are the data ‘rich’?</b> Mixed. Little detail is provided in relation to the contexts of the data, only a limited sense of the detail and depth of participants’ views is provided and there is no comparative element.</p>	<p>patients in appropriately designed rehabilitation programmes’ (p71). These practitioners were working at a residential intermediate care facility.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Partly. An ethics committee approved the research however no details are provided in relation to consent processes.</p> <p><b>Were service users involved in the study?</b> No. No indication that service users were involved in design of the study or interpretation of findings.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study reports the views of physiotherapists working in intermediate care.</p>	<p>Although this appears to be a generally well-conducted study the lack of information regarding whether data was double coded and sometimes somewhat unclear links between the data and the conclusions it is not possible to award a higher quality rating to this study.</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>design/methodology?</b> Somewhat defensible. The authors provide a relatively clear rationale for their chosen data collection and analysis techniques; however although the sampling processes used appear appropriate, a similar level of justification is not provided.</p> <p><b>How well was the data collection carried out?</b> Somewhat appropriately. The data collection methods are appropriate to the research question, however very little detail is reported in relation to this except to note that this was conducted via focus groups and semi-structured interviews, and there are only very minimal details provided in relation to data management and record-keeping.</p>	<p><b>Is the analysis reliable?</b> Unreliable. The authors do not report whether data were coded by more than 1 researcher and there is no indication that participants were able to provide feedback on transcripts or data.</p> <p><b>Are the findings convincing?</b> Convincing. The findings are clearly and coherently presented and an appropriate number of adequately referenced quotes are included.</p> <p><b>Are the conclusions adequate?</b> Somewhat adequate. Although the authors' conclusions are generally plausible and coherent and there is a reasonable discussion regarding the implications of the research, the links between these conclusions and the authors' interpretation are not always clear. In addition, the authors do not clearly discuss</p>	<p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. Physiotherapists working in intermediate care.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes.</p> <p><b>(For views questions) Are the views and experiences reported relevant to the guideline?</b> Yes. The study reports the views of physiotherapists on providing rehabilitation in intermediate care settings to service users with a 'negative social evaluation' (service users perceived to be 'difficult').</p> <p><b>Was the study conducted in the UK?</b> Yes. The study was conducted in the greater London area.</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
	the limitations of their research.		

**Research question 3. Crisis response intermediate care:**

- a) What is the effectiveness and cost effectiveness of crisis response intermediate care?**
- b) What are the views and experiences of people using services, their families and carers in relation to crisis response intermediate care?**
- c) What are the views and experiences of health, social care and other practitioners about crisis response intermediate care?**

**Research question 3 – Findings tables – the views and experiences of people using services, their families and carers**

**1. Beech R, Henderson C, Ashby S et al. (2013) Does integrated governance lead to integrated patient care? Findings from the innovation forum. Health and Social Care in the Community 21: 598-605**

<b>Research aims</b>	<b>PICO (population, intervention, comparison, outcomes)</b>	<b>Findings</b>	<b>Overall validity rating</b>
<p><b>Study aim:</b> To explore ‘...patients’ perceptions of the care received across and within organisational boundaries ...’ (p598) in 3 areas where attempts to foster inter-organisational integration was taking place. Whilst some of the findings relate to crisis response services, the study was not specifically designed to elicit views on this type of service, and data relating to other issues or services have not been extracted.</p>	<p><b>Participants:</b></p> <ul style="list-style-type: none"> <li>• Service users and their families, partners and carers - ‘Older’ patients who had experienced a stroke, had fallen or had a diagnosis of Chronic Obstructive Pulmonary Disease. Hospital or community based staff recruited patients using the modified Appropriateness Evaluation Protocol criteria (a tool used to identify ‘... avoidable acute hospital bed use ...’ (p599). Interviews</li> </ul>	<p>The authors note that few of the patients they interviewed had been ‘diverted’ to other services at the point at which an emergency call had been made. Some practitioners are reported to have viewed out-of-hours rapid response teams positively as a result of their ability to respond more quickly than out-of-hours general practitioner services.</p> <p>Rapid response staff reported difficulties in accessing</p>	<p><b>Overall assessment of internal validity:</b></p> <p>-</p> <p>Due to the lack of details in relation to key methodological issues it is not possible to award a higher quality rating to this study.</p> <p><b>Overall assessment of external validity:</b></p> <p>+</p> <p><b>Overall validity rating:</b></p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Country:</b> UK - England.</p> <p><b>Methodology:</b> Qualitative study - Semi-structured interviews.</p> <p><b>Source of funding:</b> Government - National Institute for Health Research, Service Delivery and Organisation programme.</p>	<p>were also conducted with carers, as well as professionals involved in the care of the older person.</p> <ul style="list-style-type: none"> <li>• Professionals/practitioners - Hospital nursing staff, members of the allied health or medical team, or in community settings, members or intermediate care or rehabilitation teams. Interviews in relation to emergent findings also appear to have been conducted with senior managers however data generated by these are not reported in the paper.</li> </ul> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Not reported. Although it should be noted that the study focuses on the impacts of integrated care for 'older' patients.</li> <li>• Sex - Not reported.</li> <li>• Ethnicity - Not reported.</li> <li>• Religion/belief - Not</li> </ul>	<p>important health information out of hours, particularly if the patient's community matron or general practitioner was unavailable and access arrangements to centrally held notes or assessments were not in place.</p> <p>The authors identify accident and emergency department staff as 'key' to the provision of 'care closer to home' and they note that admission avoidance work within the hospital itself had not always been sensitive to the needs of the patient: 'Two patients recounted episodes in which they were treated in A&amp;E for fractures and discharged home, but apparently without adequate arrangements for follow-up care and support' (p601).</p> <p>The study also reports that staff at each of the 3 sites who were involved in</p>	<p>-</p> <p>Due to the lack of details in relation to key methodological issues and somewhat poor external validity it is not possible to award a higher quality rating to this study.</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>reported.</p> <ul style="list-style-type: none"> <li>• Disability - Not reported.</li> <li>• Long term health condition - Four patients had a diagnosis of Chronic Obstructive Pulmonary Disease.</li> <li>• Sexual orientation - Not reported.</li> <li>• Socioeconomic position - Not reported.</li> </ul> <p><b>Sample size:</b> Eighteen patients participated in interviews (6 patients from each of the 3 sites). Interviews were also conducted with carers, as well as professionals involved in the care of the older person however the number of these types of participants is not reported.</p> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Crisis response.</li> <li>• Describe intervention - The</li> </ul>	<p>providing ‘care closer to home’ felt that ‘... opportunities were being missed to prevent ‘avoidable’ acute bed use. A key challenge was to ensure that the existence and function of these services was known to potential referrers’ (p601).</p> <p>One patient is quoted as being satisfied with the care provided by a respiratory rapid response team after being referred by a hospital observation ward: “I just couldn’t believe it. It all sort of clicked into place. I thought this is actually going to happen ... I came home and I just couldn’t believe it, the phone rang and [they] said ‘We’ll be here in half an hour’ – and they were” (Mrs I, Site 2, quoted on p602). The authors suggest in their discussion that there was an ‘overreliance’ on traditional referral mechanisms and</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>study includes information relating to a rapid response service that appears to meet the definition of crisis response as described in the National Audit of Intermediate Care.</p> <ul style="list-style-type: none"> <li>• Delivered by - No details in relation to rapid response team members are reported.</li> <li>• Delivered to - 'Older' patients who had experienced a stroke (n=1), had fallen (n=13) or had a diagnosis of Chronic Obstructive Pulmonary Disease (n=4). There are no details in relation to service eligibility criteria.</li> <li>• Duration, frequency, intensity, etc. - Not reported.</li> <li>• Key components and objectives of intervention - Not reported.</li> <li>• Content/session titles - N/A.</li> <li>• Location/place of delivery - The service appears to have been delivered in the</li> </ul>	<p>services at times of crisis. This is attributed to a lack of availability of rapid response services as well as a lack of awareness amongst some professionals that these types of 'care closer to home' services are available. Patients are also reported to have suggested poor signposting to alternative forms of crisis care as an issue.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	person's own home.		

**2. Oh KM, Warnes AM, Bath P (2009) Effectiveness of a rapid response service for frail older people. Nursing Older People 21: 25-31**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> To examine the effect of a Rapid Response Service on older people by evaluating its positive achievements and patients' satisfaction with its care, using both quantitative and qualitative methods.</p> <p><b>Country:</b> UK – Barnsley.</p> <p><b>Methodology: Mixed methods.</b> Qualitative study - Quantitative and qualitative data collected using questionnaire surveys and interviews.</p> <p><b>Source of funding:</b> Not reported</p>	<p><b>Participants:</b> Service users and their families, partners and carers – Rapid Response Service users.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Mean age 81.4 years (SD 7.1).</li> <li>• Sex - 92/150 (62%) women</li> <li>• Ethnicity - Not reported.</li> <li>• Religion/belief - Not reported.</li> <li>• Disability - Not reported.</li> <li>• Long term health condition - Health conditions of participants: 1. Injuries from falls (n=48); 2. Chest infection, chronic obstructive pulmonary disease or asthma (n=23); 3. General deterioration (n=17); 4. Pain</li> </ul>	<p><b>Statistical data -</b></p> <p><b>Change in service use 90 days after discharge</b> The increase in service use after discharge could be interpreted that the multidisciplinary Rapid Response Service team assessment provided quick access to health and social care support to meet the specific needs of some older people with chronic conditions.</p> <p><b>Number of patients with increased or unchanged service:</b></p> <ul style="list-style-type: none"> <li>• Home care - increased service - n=12, same or less - n=62.</li> </ul>	<p><b>Overall assessment of internal validity:</b> -</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>in the knee, leg, hip or back (n=11); 5. Infection on leg (n=10); 6. Urinary tract infection (n=10); 7. Cerebrovascular accident or transient ischaemic attack (n=9); 8. Heart failure (n=5), 9. Other problems including diabetes, bowel problem, hypertension and pain in palliative care patients (n=17). 10. 72% (n=108) admitted through GP referrals, while 23% (n=34) were admitted through the hospital emergency department. 11. The mean Barthel Index score was 70.7 (SD=22.4), with scores ranging from 0 = completely dependent to 100 = completely independent. 12. The mean Instrumental Activities of Daily Living score was 7.4 (SD=3.8) with scores ranging from 0 = completely dependent to 16 = completely independent.</p> <ul style="list-style-type: none"> <li>Sexual orientation - Not</li> </ul>	<ul style="list-style-type: none"> <li>Respite care - increased service - n=15, same or less - n=59.</li> <li>Meals delivered - increased service - n=9, same or less - n=65.</li> <li>Aids and adaptations - increased service - n=14, same or less n=60.</li> <li>Physiotherapy - increased service - n=8, same or less - n=66.</li> <li>Neighbourhood support - increased service - n=5, same or less - n=69.</li> <li>Day care - increased service - n=10, same or less - n=64</li> <li>Home help - increased service - n=15, same or less - n=59</li> <li>Home loans - increased service - n=25, same or less - n=47</li> <li>Alarm system installed - increased service - n=7, same or less - n=67</li> <li>District nursing - increased</li> </ul>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>reported.</p> <ul style="list-style-type: none"> <li>• Socioeconomic position - 26% married; 73% lived alone.</li> </ul> <p><b>Sample size:</b> 150 Rapid Response Service users.</p> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Intermediate care - crisis response.</li> <li>• Describe intervention - The Rapid Response Service, in collaboration with general practitioners provides a 24-hour facility for assessment and care delivered in the patient's own home and, when required, in a local authority resource centre or nursing home. Rapid Response Service aims to reduce the rate of emergency hospital admissions. The criteria for referral would be patients aged 60 or more years, who would otherwise be admitted</li> </ul>	<p>service - n=7, same or less - n=67</p> <ul style="list-style-type: none"> <li>• Health visitor - increased service - n=8, same or less - n=66</li> <li>• Chiropodist - increased service - n=6, same or less - n=68</li> </ul> <p>NB. Total n=150, data missing for 76.</p> <p><b>Narrative findings –</b></p> <p><b>Features of care that satisfied:</b></p> <ul style="list-style-type: none"> <li>• Staff attitudes, their sensitivity to patients and good staff patient relationships were frequently reported "The respect from the rapid response team is first class. They are truly 'guardian angels' and their kindness has no boundaries" (p28).</li> <li>• Being treated in the home or in a home-like</li> </ul>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>to hospital, whose GPs accepted continuing medical responsibility, and who agreed to the care plan instead of normal hospital care. The service was to be provided for a maximum of 7 days at the patient's home, or for 14 days at a resource centre or care home. The plan was to achieve an assessment within 2 hours of a referral and to work closely with the referrer to set an appropriate care plan.</p> <ul style="list-style-type: none"> <li>• Delivered by - Nurses, support workers, a physiotherapist, an occupational therapist, a social worker and clerical support.</li> <li>• Delivered to - Old and vulnerable people who may need acute nursing care and social support in patients' own homes.</li> <li>• Duration, frequency, intensity, etc. - Provided for a maximum of 7 days at the</li> </ul>	<p>environment "It's more personal and much better than hospital care.....I preferred to be at home.....I don't like to be around sick people" (p28).</p> <ul style="list-style-type: none"> <li>• Rapid response to needs and access to services, rapid assessment and care provided by Rapid Response Service "I had spent 6 hours in A&amp;E waiting for a bed. Within 2 hours of the Rapid Response Service coming, I was found a bed in a nearby nursing home for 3 nights" (p29).</li> </ul> <p><b>Features of care that dissatisfied:</b></p> <ul style="list-style-type: none"> <li>• Inconvenient facilities and insufficient equipment and material supplies "I was satisfied with all the treatment received with the exception of insufficient pads for my complaint</li> </ul>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>patient's home, or for 14 days at a resource centre or care home.</p> <ul style="list-style-type: none"> <li>• Content/session titles - Not reported.</li> <li>• Location/place of delivery - At a resource centre or care home.</li> <li>• Describe comparison intervention – N/A.</li> </ul> <p><b>Outcomes measured:</b></p> <ul style="list-style-type: none"> <li>• Satisfaction with services.</li> <li>• Service outcomes.</li> <li>• Change in service use.</li> </ul> <p><b>Follow-up:</b> Service use measured 90 days after discharge.</p>	<p>[incontinence]" (p29).</p> <ul style="list-style-type: none"> <li>• Arrangements for care and recovery, impersonal nature of care, early dinner and bedtimes "Overall the standard of care I received was quite good, but at times I found it difficult to cope with the other nursing home residents ... with patients suffering from dementia, who were wandering and shouting" (p29).</li> <li>• Poor communication between the Rapid Response Service team and other care professionals or informal carers "There appeared to be a lack of communication between the rapid response team and the district nurse about my insulin injection times ..." (p30).</li> <li>• Inappropriate medical care and a lack of support from the general practitioner</li> </ul>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>during and after the Rapid Response Service care episode. "The rapid response team's initial response was excellent and I was placed very quickly in (a private nursing home which provided beds and care for the Rapid Response Service), but I have a serious concern about the medical care there. I deteriorated in the first week" (p30).</p> <ul style="list-style-type: none"> <li>• Insufficient or limited duration of care, Rapid Response Service team visits insufficient to meet their needs. "My specific illness was treated and monitored, but no attention was paid to my loss of appetite ..... Not enough interest was shown otherwise" (p30).</li> </ul>	

### Research question 3 – Findings tables - Health, social care and other practitioners views and experiences

#### 1. Oh KM and Warnes AM (2010) A nurse-led rapid response service for frail older people: An assessment. British Journal of Community Nursing 15: 333-40

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The study focuses on a nurse-led Rapid Response Service for frail older people. The authors aimed to report practitioners 'assessments' of the service, and participants included team members as well as other professionals involved with the team. In particular, the authors were interested in professionals' views regarding the type of patient for whom the service was most appropriate, and their views on the services 'strengths and limitations' (p334).</p> <p><b>Country:</b> United Kingdom - Barnsley.</p> <p><b>Methodology:</b> Survey - Cross-sectional postal survey.</p>	<p><b>Participants:</b> Professionals/practitioners - Multidisciplinary team members of the Rapid Response Service and 3 groups of practitioners involved with the service - those who referred patients to the service such as accident and emergency and admission ward staff at Barnsley District General Hospital, district nurses, general practitioners, and social workers; those involved in the care of patients accessing the service (e.g. social services staff working at local resource centres or staff in nursing or residential homes); practitioners involved in follow-up care of patients such as district nurses and social workers.</p>	<p>Respondents were instructed to specify older people's health problems for which the service could be an appropriate response, as well as naming 3 positive characteristics and 3 limitations of the service.</p> <p><b>Health problems to which the service was thought to be an appropriate response:</b> The authors highlight in their narrative that the 3 most frequently suggested problems were chest infections or chronic obstructive pulmonary disease, falls, and medical or physical deterioration. They note that although around 10% of each group suggested 'deterioration',</p>	<p><b>Overall assessment of internal validity:</b> - Due to the lack of details in relation to key methodological issues it is not possible to award a higher quality rating to this study.</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> - Due to the lack of details in relation to key methodological issues it is not possible to award a higher quality rating to this study.</p>

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<p><b>Source of funding:</b> Not reported.</p>	<p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Not reported.</li> <li>• Sex - Not reported.</li> <li>• Ethnicity - Not reported.</li> <li>• Religion/belief - Not reported.</li> <li>• Disability - Not reported.</li> <li>• Long term health condition - Not reported.</li> <li>• Sexual orientation - Not reported.</li> <li>• Socioeconomic position - Not reported.</li> </ul> <p><b>Sample size:</b> N=120.</p> <ul style="list-style-type: none"> <li>• Rapid Response Service team members n=15 (n=3 team leaders, n=4 staff nurses, n=4 care assistants, n=1 physiotherapist, n=1 occupational therapist, n=1 social worker, n=1 co-ordinator).</li> <li>• Practitioners involved in referrals or follow-up care n=78 (n=2 district nurses, n=39 general practitioners,</li> </ul>	<p>responses were on the whole quite different between groups. They highlight the fact that although ‘emergency social problem’ was the second most frequently cited problem by general practitioners, and mild confusion or early dementia was the fifth most frequently cited problem by this group, these issues were not suggested at all by members of the Rapid Response team.</p> <p><b>Health problems to which the service was thought to be an appropriate response by rapid response team members - frequencies (%):</b></p> <ul style="list-style-type: none"> <li>• Chest infection or chronic obstructive pulmonary disease = 11 (28.9).</li> <li>• Falls = 8 (21.1).</li> <li>• Reduced mobility or medical deterioration = 4 (10.5).</li> <li>• Mild cerebral vascular accident or transient</li> </ul>	

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	<p>n=10 hospital staff in accident and emergency and admission wards at Barnsley District General Hospital, and n=27 social workers).</p> <ul style="list-style-type: none"> <li>Practitioners involved in general care of patients accessing the service n=27.</li> </ul> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>Intervention category - Crisis response.</li> <li>Describe intervention - Nurse-led Rapid Response service. The service is described as a 24 hour service providing assessments and care that aimed to reduce the number of emergency admissions to hospital.</li> <li>Delivered by - The service is nurse-led but is delivered in collaboration with a general practitioner. The team includes nurses, support workers, a physiotherapist and occupational therapist, and a social worker, and is</li> </ul>	<p>ischaemic attacks = 5 (13.2).</p> <ul style="list-style-type: none"> <li>Urinary tract infection = 4 (10.5).</li> <li>Emergency social problems = 0.</li> <li>Gastrointestinal infection = 1 (2.6).</li> <li>Mild confusion or early dementia = 0. Cellulitis = 3 (7.9).</li> <li>Generally unwell after recent discharge from hospital = 0. Diabetes = 1 (2.6).</li> <li>Cardiac failure = 0. Other problems (included blood pressure monitoring, gout, incontinence, ischaemic heart disease, methicillin resistant staphylococcus aureus, nutrition problems, acute illness nursing supervision, medication review, shingles, terminal illness = 1 (2.6).</li> <li>Total = 38 (100.0).</li> <li>Sample size = 15.</li> </ul>	

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	<p>supported by clerical staff. The patient's general practitioner accepted continuing medical responsibility.</p> <ul style="list-style-type: none"> <li>• Delivered to - The service was designed to respond to the needs of frail older people over the age of 60 who would otherwise be admitted to hospital.</li> <li>• Duration, frequency, intensity, etc. - The service was limited to 7 days if provided in the patients home or for 14 days if provided in a local authority resource centre or in a nursing or residential home.</li> <li>• Key components and objectives of intervention - The authors report that the service aimed to "... achieve an assessment within 2 hours of a referral and to work closely with the referrer to set an appropriate care plan" (p334).</li> <li>• Content/session titles - N/A.</li> </ul>	<ul style="list-style-type: none"> <li>• Number per head = 2.5.</li> </ul> <p><b>Health problems to which the service was thought to be an appropriate response by general practitioners - frequencies (%):</b></p> <ul style="list-style-type: none"> <li>• Chest infection or chronic obstructive pulmonary disease = 14 (16.9).</li> <li>• Falls = 6 (7.2).</li> <li>• Reduced mobility or medical deterioration = 9 (10.8).</li> <li>• Mild cerebral vascular accident or transient ischaemic attacks = 9 (10.8).</li> <li>• Urinary tract infection = 5 (6.0).</li> <li>• Emergency social problems = 12 (14.5).</li> <li>• Gastrointestinal infection = 5 (6.0).</li> <li>• Mild confusion or early dementia = 7 (8.4).</li> <li>• Cellulitis = 4 (4.8).</li> <li>• Generally unwell after</li> </ul>	

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	<ul style="list-style-type: none"> <li>• Location/place of delivery – Patient’s own home (including nursing and residential care homes) or in a local authority resource centre if required (no further details provided).</li> </ul>	<p>recent discharge from hospital = 4 (4.8).</p> <ul style="list-style-type: none"> <li>• Diabetes = 2 (2.4).</li> <li>• Cardiac failure = 1 (1.2).</li> <li>• Other problems (included blood pressure monitoring, gout, incontinence, ischaemic heart disease, methicillin resistant staphylococcus aureus, nutrition problems, acute illness nursing supervision, medication review, shingles, terminal illness = 5 (6.0).</li> <li>• Total = (100.0).</li> <li>• Sample size = 66.</li> <li>• Number per head = 1.3.</li> </ul> <p><b>Health problems to which the service was thought to be an appropriate response by other practitioners (e.g. district nurses, Barnsley District General Hospital staff, staff working in care and nursing homes, staff working in resource</b></p>	

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		<p><b>centres, and social workers) - frequencies (%):</b></p> <ul style="list-style-type: none"> <li>• Chest infection or chronic obstructive pulmonary disease = 40 (23.4).</li> <li>• Falls = 36 (21.1).</li> <li>• Reduced mobility or medical deterioration = 18 (10.5).</li> <li>• Mild cerebral vascular accident or transient ischaemic attacks = 16 (9.4).</li> <li>• Urinary tract infection = 13 (7.6).</li> <li>• Emergency social problems = 10 (5.8).</li> <li>• Gastrointestinal infection = 13 (7.6).</li> <li>• Mild confusion or early dementia = 3 (1.8).</li> <li>• Cellulitis = 3 (1.8).</li> <li>• Generally unwell after recent discharge from hospital = 2 (1.2).</li> <li>• Diabetes = 3 (1.8).</li> <li>• Cardiac failure = 5 (2.9).</li> <li>• Other problems (included</li> </ul>	

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		<p>blood pressure monitoring, gout, incontinence, ischaemic heart disease, methicillin resistant staphylococcus aureus, nutrition problems, acute illness nursing supervision, medication review, shingles, terminal illness = 9 (5.3).</p> <ul style="list-style-type: none"> <li>• Total = 171 (100.0).</li> <li>• Sample size = 39.</li> <li>• Number per head = 4.4.</li> </ul> <p><b>Health problems to which the service was thought to be an appropriate response by all practitioners - frequencies (%):</b></p> <ul style="list-style-type: none"> <li>• Chest infection or chronic obstructive pulmonary disease = 65 (22.3).</li> <li>• Falls = 50 (17.1).</li> <li>• Reduced mobility or medical deterioration = 31 (10.6).</li> <li>• Mild cerebral vascular accident or transient</li> </ul>	

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		<p>ischaemic attacks = 30 (10.3).</p> <ul style="list-style-type: none"> <li>• Urinary tract infection = 22 (7.6).</li> <li>• Emergency social problems = 22 (7.6).</li> <li>• Gastrointestinal infection - frequency (%) = 19 (6.5).</li> <li>• Mild confusion or early dementia = 10 (3.4).</li> <li>• Cellulitis = 10 (3.4).</li> <li>• Generally unwell after recent discharge from hospital = 6 (2.1).</li> <li>• Diabetes = 6 (2.1).</li> <li>• Cardiac failure = 6 (2.1).</li> <li>• Other problems (included blood pressure monitoring, gout, incontinence, ischaemic heart disease, methicillin resistant staphylococcus aureus, nutrition problems, acute illness nursing supervision, medication review, shingles, terminal illness = 15 (4.9).</li> <li>• Total = 292 (100.0).</li> </ul>	

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		<ul style="list-style-type: none"> <li>• Sample size = 120.</li> <li>• Number per head = 2.4.</li> </ul> <p><b>Positive features of the Rapid Response Service:</b> The authors found that the 3 most frequently cited positive features of the Rapid Response Service (by all types of practitioner) were a perceived ability to prevent admission to hospital; as a rapid response to the needs of the patient (e.g. in terms of nursing; occupational therapy, physiotherapy and social care, or provision of prosthetic equipment and 'free placement'); and as a means of enabling patients to remain at home. It is noted that 'assessment, care, treatment and appropriate follow-up discharge care by a multidisciplinary team' was suggested regularly by all types of practitioners. In contrast, although involvement of informal</p>	

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		<p>caregivers in care, enhanced collaboration between health and social care practitioners, and rapid rehabilitation were benefits that general practitioners and other types of practitioner identified, these attributes were not suggested by members of the Rapid Response team.</p> <p>General practitioners also suggested positive features associated with nursing such as monitoring of conditions, supervision of care, and oversight of medication adherence. The authors report that social workers were 'most likely' to suggest that positive features of the service were that it prevented premature care home entry and relieved the workload of other practitioners, but that these benefits were not cited by any 'other care staff'. Some general practitioners are reported to have</p>	

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		<p>suggested that referrals to the team were faster and simpler than admitting patients to hospital. For practitioners who suggested that the service allowed people to remain in their own home, some are reported to have suggested that patients treated by the team were less likely to lose ‘... confidence in their own ability ...’ (p337) than those treated in hospital and were also able to avoid the types of complication that can arise in hospital (e.g. infections).</p> <p><b>Positive features of the Rapid Response Service suggested by rapid response team members - frequencies (%):</b></p> <ul style="list-style-type: none"> <li>• ‘Prevent a hospital admission’ = 8 (19.0).</li> <li>• ‘Quick response to needs for nursing care, occupational therapy, physiotherapy, social care,</li> </ul>	

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		<p>free placement and equipment' = 7 (16.7).</p> <ul style="list-style-type: none"> <li>• 'Enable people to stay in the familiar and supportive surroundings of their own home' = 11 (26.2).</li> <li>• 'Assessment, care, treatment and appropriate follow-up discharge care by a multidisciplinary team' = 6 (14.3).</li> <li>• 'Flexible patient arrangements in community through joint working with social services and the private sector' = 5 (11.9).</li> <li>• '24-hour, seven-day service' = 3 (7.1).</li> <li>• 'Response to emergency social problem for a patient or their relatives' = 1 (2.4).</li> <li>• 'Better liaison between health and social services through joint working' = 0 (0.0).</li> <li>• 'Supervision and monitoring' = 0 (0.0).</li> </ul>	

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		<ul style="list-style-type: none"> <li>• 'Rapid rehabilitation' = 0 (0.0).</li> <li>• Others (including '... the involvement of informal caregivers in care, the avoidance of premature entry to a care home, taking work from overstretched professionals, administering medication via intravenous injection at home, clear care pathways, and £100 reimbursement for medical responsibility' p336) = 1 (2.4). Total = 42 (100).</li> <li>• Sample size = 15.</li> <li>• Number per head = 2.8.</li> </ul> <p><b>Positive features of the Rapid Response Service suggested by general practitioners - frequencies (%):</b></p> <ul style="list-style-type: none"> <li>• 'Prevent a hospital admission' = 14 (15.6).</li> <li>• 'Quick response to needs</li> </ul>	

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		<p>for nursing care, occupational therapy, physiotherapy, social care, free placement and equipment' = 19 (21.1).</p> <ul style="list-style-type: none"> <li>• 'Enable people to stay in the familiar and supportive surroundings of their own home' = 15 (16.7).</li> <li>• 'Assessment, care, treatment and appropriate follow-up discharge care by a multidisciplinary team' = 12 (13.3).</li> <li>• 'Flexible patient arrangements in community through joint working with social services and the private sector' = 13 (14.4).</li> <li>• '24-hour, seven-day service' = 2 (2.2).</li> <li>• 'Response to emergency social problem for a patient or their relatives' = 3 (3.3).</li> <li>• 'Better liaison between health and social services through joint working' = 1</li> </ul>	

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		<p>(1.1).</p> <ul style="list-style-type: none"> <li>• 'Supervision and monitoring' = 7 (7.8).</li> <li>• 'Rapid rehabilitation' = 1 (1.1).</li> <li>• Others (including '... the involvement of informal caregivers in care, the avoidance of premature entry to a care home, taking work from overstretched professionals, administering medication via intravenous injection at home, clear care pathways, and £100 reimbursement for medical responsibility' p336) = 3 (3.3). Total = 90 (100).</li> <li>• Sample size = 39.</li> <li>• Number per head = 2.3.</li> </ul> <p><b>Positive features of the Rapid Response Service suggested by other practitioners (e.g. district nurses, Barnsley District</b></p>	

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		<p><b>General Hospital staff, staff working in care and nursing homes, staff working in resource centres, and social workers) - frequencies (%):</b></p> <ul style="list-style-type: none"> <li>• 'Prevent a hospital admission' = 32 (20.4).</li> <li>• 'Quick response to needs for nursing care, occupational therapy, physiotherapy, social care, free placement and equipment' = 26 (16.6).</li> <li>• 'Enable people to stay in the familiar and supportive surroundings of their own home' = 24 (15.3).</li> <li>• 'Assessment, care, treatment and appropriate follow-up discharge care by a multidisciplinary team' = 30 (19.1).</li> <li>• 'Flexible patient arrangements in community through joint working with social services and the private sector' = 14</li> </ul>	

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		<p>(8.9).</p> <ul style="list-style-type: none"> <li>• '24-hour, seven-day service' = 9 (5.7).</li> <li>• 'Response to emergency social problem for a patient or their relatives' = 5 (3.2).</li> <li>• 'Better liaison between health and social services through joint working' = 8 (5.1).</li> <li>• 'Supervision and monitoring' = 0 (0.0).</li> <li>• 'Rapid rehabilitation' = 3 (1.9).</li> <li>• Others (including '... the involvement of informal caregivers in care, the avoidance of premature entry to a care home, taking work from overstretched professionals, administering medication via intravenous injection at home, clear care pathways, and £100 reimbursement for medical responsibility' p336) = 6 (3.8).</li> </ul>	

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		<ul style="list-style-type: none"> <li>• Total = 157 (100).</li> <li>• Sample size = 66.</li> <li>• Number per head = 2.4.</li> </ul> <p><b>Positive features of the Rapid Response Service suggested by all practitioners - frequencies (%):</b></p> <ul style="list-style-type: none"> <li>• “Prevent a hospital admission” = 54 (18.7)</li> <li>• “Quick response to needs for nursing care, occupational therapy, physiotherapy, social care, free placement and equipment” = 52 (18.0)</li> <li>• “Enable people to stay in the familiar and supportive surroundings of their own home” = 50 (17.3)</li> <li>• “Assessment, care, treatment and appropriate follow-up discharge care by a multidisciplinary team” = 48 (16.6) “Flexible patient arrangements in community through joint</li> </ul>	

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		<p>working with social services and the private sector” = 32 (11.1).</p> <ul style="list-style-type: none"> <li>• “24-hour, seven-day service” = 14 (4.8).</li> <li>• “Response to emergency social problem for a patient or their relatives” = 9 (3.1).</li> <li>• “Better liaison between health and social services through joint working” = 9 (3.1).</li> <li>• “Supervision and monitoring” = 7 (2.4).</li> <li>• “Rapid rehabilitation” = 4 (1.4).</li> <li>• Others (including “... the involvement of informal caregivers in care, the avoidance of premature entry to a care home, taking work from overstretched professionals, administering medication via intravenous injection at home, clear care pathways, and £100 reimbursement</li> </ul>	

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		<p>for medical responsibility.” p336) = 10 (3.5).</p> <ul style="list-style-type: none"> <li>• Total = 289 (100).</li> <li>• Sample size = 120.</li> <li>• Number per head = 2.4.</li> </ul> <p><b>Limitations of the Rapid Response Service:</b> Respondents were also asked to suggest 3 problems associated with the Rapid Response Service and the authors report that there was considerable variation between groups in relation to this.</p> <p>The most frequently suggested limitation (overall) was that the service tended to be provided in nursing and residential care homes, which was reportedly perceived as inappropriate. The authors state that this was a concern for general practitioners and social workers who felt that the service did not have the capacity required to deliver</p>	

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		<p>in-home 24-hour care across a wide geographical region. In contrast, this concern was not raised by Rapid Response team members.</p> <p>The second most frequently suggested limitation (overall) was concern that the service was being used as a means of achieving 'free care'. The authors report that this was regularly raised by Rapid Response team members and social workers, but was only suggested by a small number of general practitioners.</p> <p>The third most frequently suggested issue (overall) was a concern that the services eligibility criteria were inappropriate. The authors note that although this was suggested by all types of practitioners, the reasons for suggesting this varied.</p>	

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		<p>Rapid Response team members are reported to have felt that practitioners based in accident and emergency departments 'referred anyone', and that other practitioners used the service as a means of accessing social services, especially where patients with long-term medical conditions, mental health conditions or social care problems were involved. This was perceived as leading to 'pointless' assessments that wasted the time of the team.</p> <p>In contrast, general practitioners are reported to have viewed the eligibility criteria as too narrow which made it "... impossible to provide the full range of intermediate care services ..." (authors p338) The authors also report that whilst general practitioners recognised that the service</p>	

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		<p>should not be used in place of acute care, they felt that the service had refused to accept patients whose needs were at the sub-acute level.</p> <p>The fourth most frequent response (overall) was that the innovative multidisciplinary and collaborative features meant that the service only began to work effectively after a significant amount of time had elapsed. This was a concern raised by members of the Rapid Response team and other practitioners (although not by general practitioners). The Rapid Response team are reported to have experienced difficulties with particular disciplines, as well as concerns raised by night staff and their own uncertainty as issues that they had to contend with during the first year of operation. The</p>	

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		<p>authors report that before a social worker was recruited to the team, the mandatory assessment conducted by a social worker before a patient can be discharged from the service was often delayed and that this in turn meant that new patients could not be admitted to the service. The fifth most frequently suggested limitation (overall) was the additional work which the service generated for general practitioners. Although, this concern was the fifth most frequent response, this was almost entirely as a result of concerns raised by general practitioners themselves. General practitioners are reported to have suggested that a shortage of hospital beds led accident and emergency based professionals to make referrals to the team without consultation which in turn</p>	

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		<p>added to their workload. Whilst extra work without a corresponding increase in remuneration was a concern, some general practitioners emphasised that their main concern was that they did not have the time to do this extra work rather than that they were not being financially compensated for it.</p> <p>The joint sixth most frequently cited concern (overall) in relation to the service was the fact that it was time-limited and of a very short duration. This was identified as an issue by general practitioners and the group of 'other' practitioners, although not by members of the Rapid Response team. Some respondents are reported to have suggested the time-limited care "... regardless of the stage of the patient's recovery, was unrealistic and did not meet</p>	

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		<p>the needs of older people” (p339).</p> <p>The other concern that was sixth most frequently cited was that the Rapid Response team made ‘misleading medical assessments’ (p339) (no further details provided), which was raised mainly by general practitioners but also by some social workers and hospital staff. General practitioners are also reported to have felt that it was difficult to conduct diagnostic tests or rapid investigations in non-hospital settings and that this had resulted in incorrect diagnoses or failure to address needs linked to particular conditions.</p> <p>The authors report that some practitioners identified communication as sometimes problematic. Staff working in nursing/residential care</p>	

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		<p>homes or local authority resource centres are reported to have felt that they had to admit patients at too short notice and with only minimal patient information. This meant that they did not have the time to assess patients before admission. These respondents are also reported to have suggested that they were not given enough information regarding transport or the post-discharge care which the patient required.</p> <p>The authors also state that some practitioners were concerned that the large number of professionals involved in care 'bothered' patients and their family, with general practitioners and staff in nursing/residential care homes noting that patients had been asked the same questions by a number of different professionals.</p>	

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		<p>Some practitioners are reported to have felt that the Rapid Response Service 'devalued' existing care services, that it's funding reduced the funds available for other services, had led to positions being made redundant, and that the care the service provided was of a poorer quality than community care. Some respondents are reported to have suggested that the service had specifically diverted funds away from the local authority community care team, which was perceived as an effective interface between healthcare services and social services.</p> <p>Other issues which the authors highlight included: - social worker concerns that it was difficult to arrange follow-up care because the Rapid Response Service had raised</p>	

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		<p>the expectations of patients and their families, with some patients discharged from the service reported to have become highly dependent on high cost care packages. Social workers are also reported to have suggested that patients did not want to leave the care home they had been placed in or were reluctant to pay for social services care in their own home, and that the Rapid Response team should have given greater consideration to whether the patient's relatives or friends were able to support the patient.</p> <p><b>Limitations of the Rapid Response Service suggested by rapid response team members - frequencies (%):</b></p> <ul style="list-style-type: none"> <li>• 'Inappropriate patient placement in residential or nursing homes for the Rapid Response Service</li> </ul>	

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		<p>care' = 0 (0.0).</p> <ul style="list-style-type: none"> <li>• 'Abuse by some relatives and disciplines as a short cut to 'free home care and nursing or residential care home' = 6 (18.8).</li> <li>• 'Inadequate criteria to distinguish between medical and social needs' = 10 (31.3).</li> <li>• 'Time taken for the innovative service and multi-disciplinary to settle down' = 11 (34.4).</li> <li>• 'General practitioners' pressure of work' = 0 (0.0).</li> <li>• 'The limited duration of care is only a short-term solution' = 0 (0.0).</li> <li>• 'Missed or wrong medical assessment due to the difficulty of carrying out diagnostic tests' = 0 (0.0).</li> <li>• 'Poor communication among Rapid Response Service team members and between them and other care professionals' = 1</li> </ul>	

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		<p>(3.1).</p> <ul style="list-style-type: none"> <li>• 'Rapid Response Service devalues existing care services' = 1 (3.1).</li> <li>• 'Not a rapid response' = 0 (0.0).</li> <li>• 'Lack of publicity about the Rapid Response Service' = 1 (3.1).</li> <li>• 'Lack of collaboration with other care agencies' = 1 (3.1).</li> <li>• 'Others' (including no arrangement with a general practitioner to retain medical responsibility; a perception that patients and their relatives are overwhelmed by the number of visits and involvement of numerous professionals; poor quality care provided in nursing or residential care homes; an increase in stress for family carers; a paucity of rehabilitation facilities; a lack of resources; and</li> </ul>	

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		<p>inconsistently available intravenous medication) = 1 (3.1).</p> <ul style="list-style-type: none"> <li>• Total = 32 (100).</li> <li>• Sample size = 15.</li> <li>• Number per head = 2.1.</li> </ul> <p><b>Limitations of the Rapid Response Service suggested by general practitioners - frequencies (%):</b></p> <ul style="list-style-type: none"> <li>• 'Inappropriate patient placement in residential or nursing homes for the Rapid Response Service care' = 11 (15.5).</li> <li>• 'Abuse by some relatives and disciplines as a short cut to 'free home care and nursing or residential care home' = 2 (2.8).</li> <li>• 'Inadequate criteria to distinguish between medical and social needs' = 4 (5.6).</li> <li>• 'Time taken for the innovative service and</li> </ul>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>multi-disciplinary to settle down' = 0 (0.0).</p> <ul style="list-style-type: none"> <li>• 'General practitioners' pressure of work' = 17 (23.9).</li> <li>• 'The limited duration of care is only a short-term solution' = 6 (8.5).</li> <li>• 'Missed or wrong medical assessment due to the difficulty of carrying out diagnostic tests' = 13 (18.3).</li> <li>• 'Poor communication among Rapid Response Service team members and between them and other care professionals' = 5 (7.0).</li> <li>• 'Rapid Response Service devalues existing care services' = 6 (8.5).</li> <li>• 'Not a rapid response' = 2 (2.8).</li> <li>• 'Lack of publicity about the Rapid Response Service' = 2 (2.8).</li> <li>• 'Lack of collaboration with</li> </ul>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>other care agencies' = 0 (0.0).</p> <ul style="list-style-type: none"> <li>• 'Others' (including no arrangement with a general practitioner to retain medical responsibility; a perception that patients and their relatives are overwhelmed by the number of visits and involvement of numerous professionals; poor quality care provided in nursing or residential care homes; an increase in stress for family carers; a paucity of rehabilitation facilities; a lack of resources; and inconsistently available intravenous medication) = 3 (4.2).</li> <li>• Total = 71 (100).</li> <li>• Sample size = 39.</li> <li>• Number per head = 1.8.</li> </ul> <p><b>Limitations of the Rapid Response Service suggested by other practitioners - frequencies</b></p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>(%):</p> <ul style="list-style-type: none"> <li>• 'Inappropriate patient placement in residential or nursing homes for the Rapid Response Service care' = 20 (16.3).</li> <li>• 'Abuse by some relatives and disciplines as a short cut to 'free home care and nursing or residential care home' = 18 (14.6).</li> <li>• 'Inadequate criteria to distinguish between medical and social needs' = 11 (8.9).</li> <li>• 'Time taken for the innovative service and multi-disciplinary to settle down' = 13 (10.6).</li> <li>• 'General practitioners' pressure of work' = 1 (0.8).</li> <li>• 'The limited duration of care is only a short-term solution' = 11 (8.9).</li> <li>• 'Missed or wrong medical assessment due to the difficulty of carrying out diagnostic tests' = 4 (3.3).</li> </ul>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<ul style="list-style-type: none"> <li>• 'Poor communication among Rapid Response Service team members and between them and other care professionals' = 9 (7.3).</li> <li>• 'Rapid Response Service devalues existing care services' = 6 (4.9).</li> <li>• 'Not a rapid response' = 6 (4.9).</li> <li>• 'Lack of publicity about the Rapid Response Service' = 5 (4.1).</li> <li>• 'Lack of collaboration with other care agencies' = 5 (4.1).</li> <li>• 'Others' (including no arrangement with a general practitioner to retain medical responsibility; a perception that patients and their relatives are overwhelmed by the number of visits and involvement of numerous professionals; poor quality care provided in nursing or</li> </ul>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>residential care homes; an increase in stress for family carers; a paucity of rehabilitation facilities; a lack of resources; and inconsistently available intravenous medication) = 14 (11.4).</p> <ul style="list-style-type: none"> <li>• Total = 123 (100).</li> <li>• Sample size = 66.</li> <li>• Number per head = 1.9.</li> </ul> <p><b>Limitations of the Rapid Response Service suggested by all practitioners - frequencies (%):</b></p> <ul style="list-style-type: none"> <li>• 'Inappropriate patient placement in residential or nursing homes for the Rapid Response Service care' = 31 (13.7).</li> <li>• 'Abuse by some relatives and disciplines as a short cut to 'free home care and nursing or residential care home' = 26 (11.5).</li> <li>• 'Inadequate criteria to</li> </ul>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>distinguish between medical and social needs' = 25 (11.1).</p> <ul style="list-style-type: none"> <li>• 'Time taken for the innovative service and multi-disciplinary to settle down' = 24 (10.6).</li> <li>• 'General practitioners' pressure of work' = 18 (8.0).</li> <li>• 'The limited duration of care is only a short-term solution' = 17 (7.5).</li> <li>• 'Missed or wrong medical assessment due to the difficulty of carrying out diagnostic tests' = 17 (7.5).</li> <li>• 'Poor communication among Rapid Response Service team members and between them and other care professionals' = 15 (6.6).</li> <li>• 'Rapid Response Service devalues existing care services' = 13 (5.8).</li> <li>• 'Not a rapid response' = 8 (3.5).</li> </ul>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<ul style="list-style-type: none"> <li>• 'Lack of publicity about the Rapid Response Service' = 8 (3.5).</li> <li>• 'Lack of collaboration with other care agencies' = 6 (2.7).</li> <li>• 'Others' (including no arrangement with a general practitioner to retain medical responsibility; a perception that patients and their relatives are overwhelmed by the number of visits and involvement of numerous professionals; poor quality care provided in nursing or residential care homes; an increase in stress for family carers; a paucity of rehabilitation facilities; a lack of resources; and inconsistently available intravenous medication) = 18 (8.0).</li> <li>• Total = 226 (100).</li> <li>• Sample size = 120.</li> <li>• Number per head = 1.9.</li> </ul>	

## Review question 3 – Critical appraisal – the views and experiences of people using services, their families and carers

### 1. Beech R, Henderson C, Ashby S et al. (2013) Does integrated governance lead to integrated patient care? Findings from the innovation forum. *Health and Social Care in the Community* 21: 598-605

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Aim of the study:</b> To explore ‘...patients’ perceptions of the care received across and within organisational boundaries ...’ (p598) in 3 areas where attempts to foster inter-organisational integration was taking place. Whilst some of the findings relate to crisis response services, the study was not specifically designed to elicit views on this type of service, and data relating to other issues or services have not been extracted.</p> <p><b>Is a qualitative approach appropriate?</b> Appropriate. The study aimed to explore patient, carer, and staff perceptions of care and a qualitative approach (semi-structured interviews) is appropriate to do so.</p>	<p><b>Is the context clearly described?</b> Unclear. Very few details are provided in relation to participants or the settings in which data collection took place, and the issue of context bias is not specifically discussed by the authors.</p> <p><b>Was the sampling carried out in an appropriate way?</b> Appropriate. Purposive sampling was used to select patient participants (and their carers if possible or if permitted by the patient) and ‘snowball’ sampling was used to identify key staff involved in the care of the patient.</p> <p><b>Were the methods reliable?</b> Not sure. Data only appear to</p>	<p><b>Does the study’s research question match the review question?</b> Partly. The research was designed to explore ‘...patients’ perceptions of the care received across and within organisational boundaries ...’ (p598) in 3 areas where attempts to foster inter-organisational integration was taking place. Whilst some of the findings relate to crisis response services, the study was not specifically designed to elicit views on this type of service.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Partly. Patients provided written consent and a regional ethics</p>	<p><b>Overall assessment of internal validity:</b> - Due to the lack of details in relation to key methodological issues it is not possible to award a higher quality rating to this study.</p> <p><b>Overall assessment of external validity:</b> +</p> <p><b>Overall validity rating:</b> - Due to the lack of details in relation to key methodological issues and somewhat poor external validity it is not possible to award a higher quality rating to this study.</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Is the study clear in what it seeks to do?</b> Clear. The study has a clearly stated objective.</p> <p><b>How defensible/rigorous is the research design/methodology?</b> Defensible.</p> <p><b>How well was the data collection carried out?</b> Somewhat appropriately. The data collection methods are appropriate to the research question, however very little detail is reported in relation to this except to note that this was conducted via semi-structured interviews, and there are no details relating to data management or record-keeping.</p>	<p>have been collected by interviews however the authors state that ‘... findings were also informed by other data such as interviews with senior managers and documentary analysis’ (p 600).</p> <p><b>Are the data ‘rich’?</b> Poor. Little detail is provided in relation to the contexts of the data, only a limited sense of the detail and depth of participants’ views is provided and there is no comparative element.</p> <p><b>Is the analysis reliable?</b> Somewhat reliable. Double coding of data does not appear to have taken place and there is no indication that participants were able to provide feedback on transcripts or data however the authors report that joint coding frameworks were agreed and that meetings took place to discuss common themes and/or discrepancies.</p>	<p>committee approved the study, however consent processes for carers and practitioners are not reported. All interview transcripts were anonymised.</p> <p><b>Were service users involved in the study?</b> No. No indication that service users were involved in design of the study or interpretation of findings. Study relevance to scope</p> <p><b>Is there a clear focus on the guideline topic?</b> Partly. The study focuses on the integration of services and the impact that this can have on reducing hospital admissions for older people experiencing a health crisis. Whilst the study does not explore intermediate care specifically, some of the findings relate to crisis response services (covered under review question 3).</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Are the findings convincing?</b> Somewhat convincing. The findings are clearly and coherently presented however few quotes are included.</p> <p><b>Are the conclusions adequate?</b> Adequate.</p>	<p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. All participants appear to be adults, however it should be noted that the study focuses on care provided to 'older' adults and the findings therefore may not be generalisable.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes.</p> <p><b>Are the views and experiences reported relevant to the guideline?</b> Yes. The study reports some findings in relation to crisis response services.</p> <p><b>Does the study have a UK</b></p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
		<b>perspective?</b> Yes. Although it is not reported specifically, the research appears to have been conducted in the east of England.	

**2. Oh KM, Warnes AM, Bath P (2009) Effectiveness of a rapid response service for frail older people. Nursing Older People 21: 25-31**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To examine the effect of the Rapid Response Service on older people by evaluating its positive achievements and patients' satisfaction with its care, using both quantitative and qualitative methods.</p> <p><b>Objectives of the study clearly stated?</b> Yes. Both the quantitative and qualitative design of the study -to evaluate a rapid response service (Rapid Response Service), on its clinical and therapeutic achievements, and patients' satisfaction with its care, i.e. to examine the effect of Rapid Response Service on older</p>	<p><b>Response rate:</b> 150 (82%) completed questionnaire in Phase 1 (patients' satisfaction with previous contact with health and social services). At 90 days after discharge from the service (post-episode), 91/150 (61%) completed and returned the postal questionnaire (Phase 2).</p> <p><b>Measures for contacting non-responders?</b> Not reported for either the quantitative or qualitative design.</p> <p><b>Describes what was measured, how it was measured and the results?</b></p>	<p><b>Does the study's research question match the review question?</b> Yes. Both the quantitative and qualitative design of the study assessed the effectiveness of a rapid response (crisis response) service for frail older people in terms of service use and patient satisfaction.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. For both the quantitative and qualitative design. Ethical approval from Local Research Ethics Committee; consent sought from patients, confidentiality and freedom to</p>	<p><b>Overall assessment of internal validity:</b> -</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> +</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>people by evaluating its positive achievements and patients' satisfaction with its care.</p> <p><b>Research design clearly specified and appropriate?</b> Partly. 'Complementary, multi-method studies were used to provide quantitative evidence on the performance of the Rapid Response Service and the objective outcomes for patients, and to provide insights into the process of introducing and implementing a radically new service, in part by seeking the opinions of patients and staff' (p26). The quantitative and qualitative data were obtained using 1. Interviewer-administered questionnaire survey to examine patients' satisfaction with previous contact with health and social services. 2. Self-completed questionnaire survey and audit of patient records 90 days after discharge to measure duration of care episode and change in service use (post-episode).</p>	<p>Partly. For both the quantitative and qualitative design - patients' use of services and satisfaction with Rapid Response Service, measured by frequencies of service use and patients' views on satisfaction with service. However mean Barthel Index (physical functioning) score is provided but not as baseline vs. follow-up. Despite that Barthel Index seems to have been measured at both those points.</p> <p><b>Measurements valid?</b> Yes.</p> <p><b>Measurements reliable?</b> Partly. For both the quantitative design - frequency of service use, also the Barthel Index and activities of daily living. For the qualitative design: subjective views of satisfaction</p> <p><b>Measurements reproducible?</b> Partly. Barthel Index is reproducible and we</p>	<p>withdraw from study assured.</p> <p><b>Were service users involved in the study?</b> Yes. For both the quantitative and qualitative design of the study -Rapid Response Service users participated in the study.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. Both the quantitative and qualitative design of the study - effectiveness of a rapid response (crisis response) service for older people.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. Adults using the Rapid Response Service.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. Both the quantitative and qualitative design of the study - Rapid</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Clear description of context?</b> Yes. Both the quantitative and qualitative design of the study – Rapid Response Service in the community.</p> <p><b>References made to original work if existing tool used?</b> Unclear. Not reported.</p> <p><b>Reliability and validity of new tool reported?</b> Unclear. Testing or piloting of questionnaires not reported.</p> <p><b>Survey population and sample frame clearly described? Partly.</b> People aged <math>\geq 65</math> years referred to Rapid Response Service. Cognitively impaired people were excluded from the evaluation because they would be unable to comprehend the satisfaction survey.</p> <p><b>Representativeness of sample is described?</b> No. For both the</p>	<p>assume the satisfaction survey is but this is not clear.</p> <p><b>Basic data adequately described?</b> Yes.</p> <p><b>Results presented clearly, objectively and in enough detail for readers to make personal judgements?</b> Partly.</p> <p><b>Results internally consistent?</b> No. For the quantitative design - data were missing from 76 (50%) patients on outcomes of service use.</p> <p><b>Data suitable for analysis?</b> Partly. For the quantitative design - frequency of service use (note missing data from 50% of participants). For the qualitative design - yes.</p> <p><b>Clear description of data collection methods and analysis?</b> Partly. For the quantitative design - an interviewer-administered questionnaire survey to</p>	<p>Response Service in the community.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. Crisis response intermediate care.</p> <p><b>Are the views and experiences reported relevant to the guideline?</b> Yes. Both the quantitative and qualitative design of the study - effectiveness of a rapid response (crisis response) service for older people in terms of service use and patient satisfaction.</p> <p><b>Does the study have a UK perspective?</b> Yes. Barnsley.</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>quantitative and qualitative design - no details given.</p> <p><b>Subject of study represents full spectrum of population of interest?</b> Unclear. For both the quantitative and qualitative design - no details given.</p> <p><b>Study large enough to achieve its objectives, sample size estimates performed?</b> Unclear. For both the quantitative and qualitative design - no details given.</p> <p><b>All subjects accounted for?</b> Yes. For both the quantitative and qualitative design. 150 (82%) completed an interviewer-administered questionnaire (Phase 1). At 90 days after discharge from the service, 91/150 (61%) completed and returned the postal questionnaire (Phase 2), 25 (17%) had died.</p> <p><b>All appropriate outcomes considered?</b> Partly. For both</p>	<p>examine patients' satisfaction with previous contact with health and social services at phase 1. A self-completion questionnaire survey and audit of patient records were conducted 90 days after discharge to measure duration of care episode and change in service use (post-episode, phase 2). Descriptive statistics (frequencies) analysis. Limited details about questionnaire content, piloting and testing of questionnaires prior to use. For the qualitative design - this included interviews in addition to the survey methods. Responses to the open-ended questions on satisfaction provided evidence of service satisfaction or dissatisfaction. Interview data were transcribed and grouped into themes for content analysis. Limited details on content of interviews.</p> <p><b>Methods appropriate for the data?</b></p>		

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>the quantitative and qualitative design - yes, in terms of service use and patient satisfaction although admission avoidance (the objective of the service) is not measured.</p>	<p>Yes. For both the quantitative and qualitative design.</p> <p><b>Statistics correctly performed and interpreted?</b> Partly. For the quantitative design - correctly performed but not correctly interpreted (missing data from 50% of participants, see table 1).</p> <p><b>Response rate calculation provided?</b> Yes - for quantitative design only. 150 (82%) completed an interviewer-administered questionnaire (phase 1). At 90 days after discharge from the service, 91/150 (61%) had completed and returned the postal questionnaire (phase 2). Assumed same for qualitative data.</p> <p><b>Methods for handling missing data described?</b> No. For both the quantitative and qualitative design - no.</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Difference between non-respondents and respondents described?</b> No. For both the quantitative and qualitative design - no.</p> <p><b>Results discussed in relation to existing knowledge on subject and study objectives? Yes.</b></p> <p><b>Limitations of the study stated? Partly.</b> Not methodologically, especially on missing data on service use (Table 1), but authors suggest that a full evaluation of the 'hospital avoidance' effect of a Rapid Response Service requires an extended prospective longitudinal design.</p> <p><b>Results can be generalised? Partly.</b> Due to missing data and subjective views of Rapid Response Service users. These views could vary in different areas where health and social services provisions differed. Also unclear if missing</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>data (76/150 participants also referred to qualitative data).</p> <p><b>Appropriate attempts made to establish 'reliability' and 'validity' of analysis?</b> Unclear.</p> <p><b>Conclusions justified?</b> Partly. The need to have a shared understanding between service providers and referrers about the eligibility criteria is justified on the basis of results. However they hypothesise that hospital bed days can be reduced when there's no evidence for this (because they didn't collect data).</p>		

### Review question 3 – Critical appraisal - Health, social care and other practitioners' views and experiences

1. Oh KM and Warnes AM (2010) A nurse-led rapid response service for frail older people: An assessment. *British Journal of Community Nursing* 15: 333-40

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<b>Study aim:</b> The study focuses on a nurse-led Rapid Response	<b>Response rate:</b> The authors do not report on response rate.	<b>Does the study's research question match the review</b>	<b>Overall assessment of internal validity:</b>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>Service for frail older people. The authors aimed to report practitioners 'assessments' of the service, and participants included team members as well as other professionals involved with the team. In particular, the authors were interested in professionals' views regarding the type of patient for whom the service was most appropriate, and their views on the services 'strengths and limitations' (p334).</p> <p><b>Objectives of the study clearly stated?</b> Yes. The aims of the study are clear.</p> <p><b>Research design clearly specified and appropriate?</b> Yes. The research design is clearly specified by the authors (cross-sectional survey with open-ended items so that views data could be added) although the data resulting from this are not very rich. It may have been more appropriate to conduct focus groups or interviews.</p>	<p><b>Measures for contacting non-responders?</b> There are no details regarding measures used to contact non-responders.</p> <p><b>Describes what was measured, how it was measured and the results?</b> Yes. Respondents were asked to list the health problems of older people for which the service was an appropriate response, to suggest 3 positive aspects of the service, and to list 3 limitations of the service.</p> <p><b>Measurements valid?</b> N/A. The authors devised a bespoke survey that was piloted (no further details provided).</p> <p><b>Measurements reliable?</b> N/A. The authors devised a bespoke survey that was piloted (no further details provided).</p>	<p><b>question?</b> Yes. The study focuses on a nurse-led Rapid Response Service for frail older people. The authors aimed to report practitioners 'assessments' of the service, and participants included team members as well as other professionals involved with the team. In particular, the authors were interested in professionals' views regarding the type of patient for whom the service was most appropriate, and their views on the services 'strengths and limitations' (p334).</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Partly. The study was approved by a research ethics committee, however the authors do not provide details on consent processes.</p> <p><b>Were service users involved in the study?</b> No.</p>	<p>-</p> <p>Due to the lack of details in relation to key methodological issues it is not possible to award a higher quality rating to this study.</p> <p><b>Overall assessment of external validity:</b> ++</p> <p><b>Overall validity rating:</b> -</p> <p>Due to the lack of details in relation to key methodological issues it is not possible to award a higher quality rating to this study.</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Clear description of context?</b> N/A. The study used a postal survey design.</p> <p><b>References made to original work if existing tool used?</b> N/A. The survey appears to have been designed specifically for this study but no details on the design process are provided.</p> <p><b>Reliability and validity of new tool reported?</b> Partly. Although the authors do not report reliability or validity data they note that the survey was piloted through "... a small number of interviews with the populations of interest" (p334).</p> <p><b>Survey population and sample frame clearly described?</b> No. The authors do not provide a clear description of the survey population or discuss their sample frame, and it is not clear whether a sampling frame was used at all.</p>	<p><b>Measurements reproducible?</b> Unclear.</p> <p><b>Basic data adequately described?</b> Partly. The study reports on the frequencies with which certain responses were received. No further details are provided.</p> <p><b>Results presented clearly, objectively and in enough detail for readers to make personal judgements?</b> Partly. The results are presented relatively clearly and objectively although very few details are provided.</p> <p><b>Results internally consistent?</b> Partly. The results are on the whole consistent although some of the percentages do not appear to be exactly correct.</p> <p><b>Data suitable for analysis?</b> Yes.</p> <p><b>Clear description of data</b></p>	<p>No indication that service users were involved in the design of the study or interpretation of the findings.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study focuses on a nurse-led rapid response service for frail older people that was considered to be equivalent to a crisis response service according to the definition given in the National Audit of Intermediate Care.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. The study reports on a survey conducted with practitioners working in a rapid response service (equivalent to crisis response) for frail older people, as well as other practitioners who had contact with the team.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Representativeness of sample is described?</b> No. The authors do not provide any details in relation to representativeness of the sample.</p> <p><b>Subject of study represents full spectrum of population of interest?</b> Unclear. Only minimal details are provided in relation to the sample and the authors do not discuss whether the sample was representative.</p> <p><b>Study large enough to achieve its objectives, sample size estimates performed?</b> Unclear. The authors do not report whether sample size estimates were performed or whether the study sample was large enough to achieve its aims. A total of 120 practitioners responded to the survey.</p> <p><b>All subjects accounted for?</b> N/A.</p> <p><b>All appropriate outcomes</b></p>	<p><b>Internal validity - performance and analysis collection methods and analysis?</b> Partly. There is a reasonably clear description of the survey design and data analysis process but this is not very detailed.</p> <p><b>Methods appropriate for the data?</b> Yes.</p> <p><b>Statistics correctly performed and interpreted?</b> Yes.</p> <p><b>Response rate calculation provided?</b> No. The authors do not report the response rate.</p> <p><b>Methods for handling missing data described?</b> N/A.</p> <p><b>Difference between non-respondents and respondents described?</b> No. No details are provided in relation to differences between respondents and non-respondents.</p>	<p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Partly. The study reports on the results of a postal survey completed by rapid response team members and other practitioners with experience of the service. The service was based in the community.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. The study reports on practitioner 'assessments' of a nurse-led Rapid Response Service for frail older people (considered to be equivalent to a crisis response service according to the definition given in the National Audit of Intermediate Care).</p> <p><b>Are the views and experiences reported relevant to the guideline?</b> Yes. The study reports on</p>	

Internal validity - approach and sample considered?	Internal validity - performance and analysis	External validity	Overall validity rating
N/A.	<p><b>Results discussed in relation to existing knowledge on subject and study objectives?</b> Partly. There is only limited discussion of the wider literature on care for frail older people, and only minimal consideration of how the findings of this study fit into the wider context.</p> <p><b>Limitations of the study stated?</b> No. The authors do not discuss the limitations of the study.</p> <p><b>Results can be generalised?</b> Unclear. Very few details are provided on the practitioners who responded to the survey and the authors do not discuss how representative the sample was. It is not therefore possible to determine whether the results of this study can be generalised.</p> <p><b>Appropriate attempts made to establish 'reliability' and</b></p>	<p>practitioner views regarding a rapid response service.</p> <p><b>Does the study have a UK perspective?</b> Yes. The study reports on the results of a survey of practitioners based in the Barnsley area.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>'validity' of analysis?</b> Unclear. There is no indication that the authors attempted to establish the reliability or validity of their analysis.</p> <p><b>Conclusions justified?</b> Partly. The author's conclusions are generally plausible however the data presented in the study are not really contextualised and it is therefore difficult to be sure that the conclusions are justified and are an accurate interpretation of the data. In addition, the analysis and detailed discussion centres almost exclusively on the 'limitations' of the service.</p>		

**Research question 4. Reablement:**

**a) What is the effectiveness and cost effectiveness of reablement?**

**b) What are the views and experiences of people using services, their families and carers in relation to reablement?**

**c) What are the views and experiences of health, social care and other practitioners about reablement?**

**Research question 4 – Findings tables – Effectiveness**

**1. Dundee City Council and Tayside NHS (2010) Home care enablement service: Evaluation. Dundee: Dundee City Council**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The study objectives were to –</p> <ul style="list-style-type: none"> <li>• ‘Determine the views of service users and other stakeholders, of the service.</li> <li>• Explore the impact of working in a different way on the home care staff.</li> <li>• Establish if enablement had a significant impact on speed of discharge from hospital.</li> <li>• Demonstrate a comparison between the service users who had completed the enablement service, and those of a trial group of service users who were</li> </ul>	<p><b>Participants:</b></p> <ul style="list-style-type: none"> <li>• Service users and their families, partners and carers.</li> <li>• Professionals/practitioners - Enablement social care staff, hospital social work teams, and independent private providers.</li> </ul> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers – n=22.</li> <li>• Intervention numbers – n=22.</li> </ul> <p>Number of focus group participants or survey</p>	<p><b>Statistical data – service outcomes -</b></p> <p>No effect sizes given or calculable.</p> <p>Total number of hours required at start of service - Control 275 vs. intervention 314.</p> <p>Total number of hours required at end of 6 week period Control 204 (25.8 reduction since start) vs. intervention 154 (51% reduction).</p>	<p><b>Overall assessment of internal validity:</b></p> <p>-</p> <p><b>Overall assessment of external validity:</b></p> <p>++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>discharged from hospital during the same period of time during the previous year. Draw from the experience in order to inform the implementation of an enablement approach across the whole of home care' (p4).</p> <p><b>Methodology:</b> Mixed methods. Qualitative (focus groups and surveys) and quantitative (analysis of data about required number of home care hours).</p> <p><b>Country:</b> UK – Scotland.</p> <p><b>Source of funding:</b> Not reported.</p>	<p>respondents, not provided.</p> <p><b>Intervention:</b> Reablement.</p> <ul style="list-style-type: none"> <li>• Description - Enablement, is described as "a time limited intensive care and support service, to support service users in order that they can learn new skills, or re-learn skills that they have lost. This approach maximises the individual's long term independence, choice and quality of life' (p3).</li> <li>• Delivered by - The workforce is not very clearly described but it appears that the enablement service was created from 2 mainstream home care teams so the majority of staff were former home care workers. A physiotherapist was also seconded to the enablement teams and a NHS senior occupational therapist was deployed for 12 hours per week to work with the hospital occupational</li> </ul>	<p>Total number of hours required at end of 6 month period: Control 279.5 (1.6% increase) vs. intervention 107 (43% reduction).</p> <p>Care services required at the end of the enablement process -</p> <p>Service users requiring no ongoing care hours: 45.</p> <p>Service users requiring a reduced number of care hours: 28.</p> <p>Service users requiring the same number of care hours: 13.</p> <p>Service users requiring an increase in hours: 3.</p> <p>Service users who were re-admitted to hospital whilst on the scheme: 20.</p> <p>Service users who went into respite care: 4.</p> <p>Total number of service users: 113.</p> <p><b>Narrative findings – service outcomes -</b></p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>therapy and physiotherapy departments on developing 'enablement plans'.</p> <ul style="list-style-type: none"> <li>• Delivered to - People being discharged from hospital.</li> <li>• Duration, frequency, intensity, etc.: 1 to 6 weeks.</li> <li>• Key components and objectives of intervention - The objective is to support people following discharge from hospital, improve their independence and reduce the amount of ongoing home care they need. Hospital social work teams screen patients using the de-selection criteria (terminal illness, dementia, Motor Neurone Disease, complex moving and handling requirements, etc.) If selected, a request for the service is made to the enablement team. If necessary a request for occupational therapy is also made - also requests for equipment which seem to be</li> </ul>	<p>Forty-five service users did not require any ongoing social care service at the end of the 6 week enablement period; this represents 60% of the service users. None of these service users had since required a service by the time of publication (2010).</p> <p><b>Narrative findings - qualitative and views and experiences data -</b></p> <p>Everyone who completed the enablement service was given a survey comprising 11 questions. The results are presented:</p> <ol style="list-style-type: none"> <li>1. Was the enablement service explained to you? Not sure 13% No 0% Yes 87%.</li> <li>2. Who explained the service to you? Did not answer 11% Social Worker/Care Manager 67% Enablement Organiser 22%.</li> <li>3. Were you informed this would be a short term</li> </ol>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>fast tracked for enablement service users. The social worker discusses the aims/objectives/nature of the enablement service with the person so it's clear this is a short term intervention. The seconded physiotherapist visits the service user on discharge and creates the enablement plan for the enablement care staff to then implement. The enablement organiser visits the service user to ensure they understand the objectives of the service. Service users are reviewed throughout and the amount/nature of support they receive is amended to reflect their progress.</p> <ul style="list-style-type: none"> <li>• Location/place of delivery - Person's own home.</li> </ul> <p><b>Comparison intervention:</b> No service (the control was created retrospectively from a randomly selected group of 22</p>	<p>service? Not sure 13% No 0% Yes 87%.</p> <p>4. Did you feel your opinion was included in your enablement plan? Yes 74% Not sure 13% No 13%.</p> <p>5. Did you receive the support you felt you needed? Yes 75% Not sure 25% No 0%.</p> <p>6. Were you satisfied with the support you received? Not sure 13% No 0% Yes 87%.</p> <p>7. Did you receive a visit from a physiotherapist? Not sure 25% No 13% Yes 62%.</p> <p>7.1 Did you find this helpful? Not sure 25% No 13% Yes 62%.</p> <p>8. Did you receive a visit from an occupational therapist? Yes 13% Not sure 13% No 0% Yes 74%.</p> <p>8.1. Did you find this helpful? No answer 13% Not sure 13% No 0% Yes 74%.</p> <p>9. Did you feel involved in the process? No answer 13% Not sure 13% No 0% Yes 74%.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>service users discharged from hospital the previous year. They were tracked for 6 months to monitor the amount of care they received in that time).</p> <p><b>Outcomes measured:</b></p> <ul style="list-style-type: none"> <li>• Satisfaction with services - Service user and practitioner satisfaction.</li> <li>• Service outcomes - Care hours required.</li> </ul> <p><b>Follow-up:</b> Six months post discharge.</p> <p><b>Costs?</b> Data on training costs are provided. Total training costs for social care workers, social care organisers and managers was £5,915</p>	<p>10. Did you feel the enablement team benefitted you? No answer 13% Not sure 13% No 0% Yes 74%.</p> <p>11. How would you rate the enablement service? Did not answer 25% V poor 0% Poor 0% Adequate 0% Good 0% V good 13% Excellent 62%.</p> <p>Qualitative findings are summarised here by practitioner group:</p> <p>Hospital Social Work Team - Generally positive feedback. For example, they felt the enablement teams had facilitated a quicker discharge from hospital in most cases. They agreed the enablement assessment should be conducted post discharge - not while in hospital. One concern was about the enablement service becoming 'blocked' if they had trouble accessing longer term care. Therefore people</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>with complex needs were seen as inappropriate for the enablement service.</p> <p>Enablement Social Care Workers (from verbal feedback during the Care Commission inspection) - Generally positive. Helping people regain independence makes their role fulfilling. They felt the loss of the physiotherapist and her knowledge when her secondment was over.</p> <p>Independent Care Providers - Independent providers weren't concerned about a lack of contract hours as a result of the enablement scheme. One criticism was that hand over from the enablement teams to the external provider could be improved - they noted inconsistency in how this is done.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Costs - The enablement teams were created from existing home care teams and the running costs are approximately the same.</p> <p>Occupational therapy - the priority given to enablement users created a backlog of others waiting for occupational therapy. To compensate for this, in the long term, another occupational therapy would need to be funded.</p> <p>Health - incurred additional costs due to the input of the hospital and community rehabilitation teams.</p>	

**2. Glendinning C, Jones K, Baxter K et al. (2010) Home Care Re-ablement Services: Investigating the longer-term impacts (prospective longitudinal study) York: Social Policy Research Unit, University of York**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<b>Study aim:</b> To examine – 1. Whether home care reablement improved outcomes	<b>Participants:</b> • Service users and their families, partners and carers.	<b>Statistical data - service user related outcomes -</b> NB. Effect size data are not	<b>Overall assessment of internal validity:</b> +

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>for people by giving them greater independence, when compared with conventional home care services.</p> <p>2. If the improved outcomes lasts over time.</p> <p>3. The cost-effectiveness of reablement</p> <p><b>Methodology:</b> Mixed methods. Quantitative data collection and analysis for users' outcomes; qualitative data collection and analysis for views and experiences of users and care professionals. Quantitative data analysis - Univariate analysis (paired t-tests, chi-squared tests and binomial tests) and multivariate analyses. Data analysis were adjusted on baseline characteristics. Multivariate regression analyses were performed employing both a fixed and random-effects model to explore outcome changes between baseline and the 12 month follow-up.</p>	<ul style="list-style-type: none"> <li>• Professionals/practitioners - Managers and front-line staff.</li> </ul> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Service users – Over 65 years of age - reablement group 93% (n=589); comparison group 92% (n=329), not significant. Family carers - The majority of informal carers were aged over 65 years. Managers and front-line staff - no details provided.</li> <li>• Sex - Service users - Female - reablement group 71% (n=455); comparison group 69% (n=248), not significant. Family carers - The majority of informal carers were also female. Managers and front-line staff - not reported.</li> <li>• Ethnicity - Service users - Black or from a minority ethnic background - reablement group 6% (n=40); comparison 6%</li> </ul>	<p>consistently reported for all outcomes. Where they were not provided, they have been calculated by the reviewing team.</p> <p>Perceived health (ranges from very good to very bad, with higher scores indicating better perceived health)</p> <p>Reablement group: The % of people perceiving their health as good or very good declined by the time of follow-up approximately 12 months after receiving reablement (baseline 31 per cent and follow-up 23 per cent). Similarly, the percentage of people in the reablement group perceiving their health to be bad or very bad increased (baseline 22 per cent and follow-up 31 per cent).</p> <p>Comparison group: The % of people perceiving their health to be good or very good</p>	<p><b>Overall assessment of external validity:</b></p> <p>++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Country:</b> UK. Nine local councils in the United Kingdom (Brighton and Hove, Croydon, Hampshire, Haringey, Leicestershire, Lincolnshire, North East Lincolnshire, Nottinghamshire and Wirral Borough).</p> <p><b>Source of funding:</b> Government - Department of Health.</p>	<p>(n=22), not significant.  Family carers - The majority of informal carers were White British or Irish.  Managers and front-line staff - not reported.</p> <ul style="list-style-type: none"> <li>• Long term health condition - Service users in the comparison group were statistically significantly more likely to have been classified as having critical or substantial levels of need than those in the reablement group (Table 3.4)  Fair Access to Care Services (reablement group n=314; comparison group n=326) - critical or substantial - reablement group 37% (n=117); comparison group 77% (n=251), p&lt;0.001.  Moderate or low - reablement group 63% (n=197); comparison group 23% (n=75), p&lt;0.001.  Activities of Daily Living – Unable to get up or down stairs - reablement group</li> </ul>	<p>remained stable (27 per cent at both baseline and follow-up) but more people felt their health was bad or very bad at follow-up (25 per cent at baseline compared to 28 per cent at follow-up).</p> <p>Perceived health, presented as an overall score -  Reablement group: There was a statistically significant deterioration in the mean score for perceived health by the time of 12 month follow-up (baseline mean 3.24 [SD 0.91]; follow-up mean 2.94 [SD 0.99]; p&lt;0.001).  Comparison group: There was no change in mean perceived health from a baseline score of 2.99 (SD 0.99) to a 12 month follow-up score of 2.96 (SD 1.04).</p> <p>Perceived quality of life (Ranges from 'so good it could not be better' to 'so bad it could not be worse' with a</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>57% (n=358) vs. 62% (n=221), not significant.</p> <p>Unable to get outdoors/walk down road - reablement group 76% (n=477) vs. 73% (n=257), not significant.</p> <p>Unable to get around indoors: 11% (n=70) vs. 16% (n=57), p&lt;0.05.</p> <p>Unable to get in/out of bed or chair - reablement group 10% (n=63) vs. 19% (n=69), p&lt;0.001.</p> <p>Unable to use toilet: 11% (n=68) vs. 17% (n=60), p&lt;0.001.</p> <p>Unable to wash face and hands - reablement group 8% (n=53) vs. 16% (n=56), p&lt;0.001.</p> <p>Unable to bath, shower or wash all over - reablement group 71% (n=453) vs. 73% (n=262), not significant.</p> <p>Unable to get dressed/undressed - reablement group 41% (n=261) vs. 46% (n=165), not significant.</p>	<p>higher score indicating better perceived quality of life)</p> <p>Direction of change in perceived health from baseline to follow-up (overall score): Reablement group (n=235) Comparison group (n=139) Perceived health improved 19% (44) 27% (38) Remained the same 40% (94) 42% (58) Perceived health declined 41% (97) 31% (43).</p> <p>Perceived quality of life, presented as an overall score</p> <p>Reablement group: There was no statistically significant change in the mean perceived quality of life score between baseline (mean 4.48, SD 1.07) and 12 month follow-up (mean 4.35, SD 1.10).</p> <p>Comparison group: there was a statistically significant (but slight) deterioration from a baseline mean score of 4.28 (SD 1.19) to a follow-up score</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>Unable to feed self: 4% (n=23) vs. 7% (n=25), p&lt;0.05.</p> <p>Unable to control bladder - reablement group 35% (n=223) vs. 44% (n=156), p&lt;0.05.</p> <p>Unable to control bowel - reablement group 17% (n=109) vs. 23% (n=83), p&lt;0.05.</p> <p>Informal carers: Reablement group (n=645) vs. comparison group (n=356)</p> <p>Received informal care from someone in same household: 27% (n=173) vs. 30% (n=106), not significant.</p> <p>Received informal care from someone outside household: 64% (n=413) vs. 63% (n=224), not significant.</p> <p>Did not receive any informal care: 15% (n=98) vs. 15% (n=54), not significant.</p> <p>Managers and front-lines staff - not reported.</p> <ul style="list-style-type: none"> <li>• Socioeconomic position - Service users - Reablement</li> </ul>	<p>of 4.05 (SD 1.10, p&lt;0.05).</p> <p>Health-related quality of life (mean EQ-5D scores by group, by time, imputed)</p> <p>Reablement group at baseline: 0.35 (n=619). Reablement group at 12 month follow up: 0.47 (n=233). Comparison group at baseline: 0.30 (n=355). Comparison group at 12 month follow up: 0.32 (n=135).</p> <p>A difference in difference analysis was conducted (to adjust for baseline differences) and the model presented (p81) shows the extent to which participants with certain characteristics achieve above or below mean average EQ-5D scores (imputed data): Shows Coefficient/ Marginal effect and (probability).</p> <p>Note that a negative</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>group vs. comparison group Widowed 52% (n=336) vs. 53% (n=190), not significant; Married/cohabiting 25% (n=161) vs. 25% (n=92) , not significant; Retired 97% (n=617) vs. 94% (n=339), not significant; Lives alone 68% (n=438) vs. 65% (n=233); Lives in privately owned household 55% (n=354) vs. 51% (n=183), not significant. Family carers: None lived alone. Managers and front-lines staff - not reported.</p> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers - Service users - at baseline, conventional home care (n=361). At 12 months n=141.</li> <li>• Intervention numbers - Service users: at baseline, reablement home care (n=654). At 12 months n=241.</li> <li>• Service users (quantitative</li> </ul>	<p>coefficient marginal effect shows that participants with that characteristic (e.g. referred from hospital) scored lower than the mean average EQ-5D score.</p> <p>T1 ADL ability 0.041 (0.023). T1 ADL ability (sqrd) 0.003 (0.033). Female -0.008 (0.674). Alone 0.016 (0.414). Owns home 0.001 (0.964). Age 0.007 (&lt;0.001). Referred from hospital -0.050 (0.081). Reablement Group at T1 0.161 (0.014). Reablement Group at T2 0.275 (0.013). Reablement Group at T1 x T1 ADL -0.025 (0.005). Reablement Group at T2 x T1 ADL -0.035 (0.015). Reablement Group at T1 x hospital referral 0.038 (0.324). Reablement Group at T2 x hospital referral 0.113</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>data collection and analysis): 1,015 people were recruited at baseline (654 reablement home care group and 361 conventional home care group). At 9 to 12 months the number of people who completed follow-up at 12 months was 241 in the reablement group and 141 in the comparison group (38% response rate and 62% attrition).</p> <p>Qualitative data collection and analysis - Semi-structured interviews were conducted with service users in each of the 5 reablement sites. A total of 34 reablement service users and 10 of their informal carers interviewed in-depth about their views of the reablement service they received.</p> <p>Managers and front-line staff in 8 sites - Focus groups comprised 37 front-line staff (with between 2 weeks and 8</p>	<p>(0.027). T2 0.002 (0.943). The net effect of using reablement services in this analysis was around 0.1 on the EQ-5D scale. This result is significant at better than the 95 per cent confidence level with a range of 0.02 to 0.18.</p> <p>Social care related quality of life (mean ASCOT scores by group, by time, imputed) Reablement group at baseline: 0.77 (n=621). Reablement group at 12 month follow up (T2): 0.80 (n=238). Comparison group at baseline: 0.76 (n=357). Comparison group at 12 month follow up (T2): 0.78 (n=138).</p> <p>A difference in difference analysis was conducted (to adjust for baseline differences) and the model</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>years of experience in the reablement service) and 3 occupational therapists. 26 reablement visits across 5 sites were observed. Service users whose visits were observed included: 12 men and 14 women, 25 were aged over 65 years (including 5 who were over 90 years old); 20 people referred following hospital discharge and 6 referred to the service from the community. None of the service users whose visits were observed were from ethnic minority populations. In each site, the researcher observed the activities of 2 different workers - one experienced and one with less experience of working in the reablement service.</p> <p><b>Intervention:</b> Home care reablement.</p> <ul style="list-style-type: none"> <li>Description - Home care reablement is described as a</li> </ul>	<p>presented (p84) shows the extent to which participants with certain characteristics achieve above or below mean average ASCOT scores (imputed data): Shows coefficient and (probability). Note that a negative coefficient marginal effect shows that participants with that characteristic (e.g. reablement group at T1) scored lower than the mean average ASCOT score.</p> <p>ADL ability (log) 0.029 (0.115).  Female -0.051 (0.612).  Female x age 0.001 (0.488).  Age 0.010 (&lt;0.001).  Age (cubed) -3.20E-07 (0.019).  Alone -0.003 (0.825).  In good health at T1 0.073 (&lt;0.001).  EQ-5D score at T1 (sqrd) 0.226 (&lt;0.001).  Referred from hospital 0.108 (0.108).</p>	

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	<p>service for: '... for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living' (Kent et al. 2000, quoted on p1). Four out of the 5 reablement sites were developed from in house home care services and the other (R2) reablement team remained part of the in house service, with care workers delivering both long term home care and reablement if a person was identified as having the potential to 're-able'. All 5 started as relatively selective pilots, taking referrals from hospital and intermediate care. Their criteria gradually broadened to be 'intake' services, for almost everyone over 18 referred for home care services (and meeting Fair Access to Care Services criteria). People</p>	<p>Critical FACs band - 0.064 (0.051).  Owns home -0.025 (0.021).  Area cost adj. (+1%) 0.337 (0.051).  Reablement Group at T1 - 0.004 (0.771).  Reablement Group at T2 0.198 (0.065).  Reablement Group at T2 x Age -0.002 (0.109).  T2 -5.77E-04 (0.97).  The net effect of using reablement services in this analysis was around 0.03 on the ASCOT scale. The authors state that this is significant at the 10% level although this is not clear from the data presented in the tables.</p> <p>Effect sizes calculated according to sample characteristics  Perceived health by sample characteristics and dependency at baseline  Age: Under 65 years:</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>with end of life care needs and those with severe dementia were excluded and 2 sites excluded people living with learning disabilities. The intervention starts with assessment and development of person centred care plans/tasks. Family members as well as service users could also be involved in goal setting. Reviews took place 1 to 2 times during the intervention period. Towards the end of reablement, managers conducted a formal review to assess whether people needed ongoing home care. People using reablement and their carers plus a senior carer were generally involved in this review. If no further care was needed, a closure date was agreed. When people had ongoing needs, the review identified the required level and transferred the person to an</p>	<p>d=0.0871; 95% Confidence Interval -0.389 to 0.5633; Over 65 years: d=0.1079; 95% CI -0.0274 to 0.2433. Gender: Male: d=0.1503; 95% CI -0.0849 to 0.3855; Female: d=0.1257; 95% CI -0.0249 to 0.2763. Ethnicity: White British or Irish: d=0.2001; 95% CI 0.064 to 0.3363; Other: d=-0.6899; 95% CI -1.14 to -0.2398. Lives alone: No: d=0.1857; 95% CI -0.0363 to 0.4077; Yes: d=0.0854; 95% CI -0.0737 to 0.2446. Owner occupier: No: d=0.1064; 95% CI -0.0899 to 0.3027; Yes: d=0.1837; 95% CI 0.0044 to 0.363. Informal carer in same household: No: d=0.1049; 95% CI -0.0486 to 0.2585; Yes: d=0.1568; 95% CI -0.0866 to 0.4001. Informal carer in another household: No: d=0.0936; 95% CI -0.1211 to 0.3082; Yes: d=0.1464; 95% CI</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>independent provider. See other elements of the intervention for the content of reablement.</p> <ul style="list-style-type: none"> <li>• Delivered by - Majority of teams included a home care manager, team leader, home care workers ('re-ableers') who had or were working towards NVQ 2 or 3. Also occupational therapists and nurses. All sites required specialist occupational therapists assessments for complex equipment but in most places reablement care workers could obtain smaller pieces of equipment.</li> <li>• Delivered to - Mostly older people were referred via hospital discharge (75%) and the rest were community referrals. People with end of life care needs were excluded as were people with severe dementia and in 1 area, people with learning disabilities were excluded.</li> <li>• Duration, frequency,</li> </ul>	<p>-0.0166 to 0.3095.  FACS (Fair Access to Care Services) level: Critical or substantial: d=0.1179; 95% CI -0.1029 to 0.3388; Moderate or low: d=-0.1238; 95% CI -0.3899 to 0.1424.  Perceived health by sample characteristics and dependency at follow-up  Age: Under 65 years: d=0.1925; 95% CI -0.6673 to 1.0524; Over 65 years: d=-0.0312; 95% CI -0.2484 to 0.1861.  Gender: Male: d=-0.0785; 95% CI -0.4663 to 0.3094; Female: d=-0.0099; 95% CI -0.2593 to 0.2395.  Ethnicity: White British or Irish: d=-0.0103; 95% CI -0.2264 to 0.2059; Other: d=-0.2104; 95% CI -1.1605 to 0.7397.  Lives alone: No: d=-0.021; 95% CI -0.4006 to 0.3585; Yes: d=-0.0501; 95% CI -0.2997 to 0.1995.  Owner occupier: No:</p>	

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	<p>intensity, etc. -Typically 5 to 6 weeks (range 1-23 weeks). The length of reablement visits was very flexible (compared with conventional home care visits). If someone needed the reablement worker to stay longer, the reablement phoned through to the office to rearrange their next call. However there was some inconsistency in the flexibility within and between sites.</p> <ul style="list-style-type: none"> <li>• Key components and objectives of intervention - All sites had similar objectives - to support service users to achieve maximum independence and rebuild confidence. Aimed to do this by moving away from time and task oriented services to flexible services focusing on helping people to things for themselves rather than doing things for them. Main components across the sites - personal</li> </ul>	<p>d=-0.0526; 95% CI -0.3896 to 0.2844; Yes: d=0.02; 95% CI -0.2482 to 0.2882.</p> <p>Informal carer in same household: No: d=0.01; 95% CI -0.2355 to 0.2554; Yes: d=-0.1876; 95% CI -0.5823 to 0.2072.</p> <p>Informal carer in another household: No: d=0.157; 95% CI -0.1531 to 0.4672; Yes: d=-0.2333; 95% CI -0.5156 to 0.049.</p> <p>Perceived quality of life by sample characteristics and dependency at baseline</p> <p>Age: Under 65 years: d=0.6033; 95% CI 0.0844 to 1.1222; Over 65 years: d=0.0987; 95% CI -0.0391 to 0.2365.</p> <p>Gender: Male: d=0.114; 95% CI -0.1252 to 0.3532; Female: d=0.1059; 95% CI -0.0528 to 0.2646.</p> <p>Ethnicity: White British or Irish: d=0.1059; 95% CI -0.0327 to 0.2444; Other: d=0.0939; 95% CI -0.3656 to</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>care, assisting with washing/dressing, practical support such as assisting with meal preparation/household duties, prompting medication, information and signposting about library services, transport etc., psychological, emotional and personal support, taking people for a walk, increasing social engagements and contacts, referrals to lunch clubs etc., advice to reduce the risk of falls, providing equipment (grab rails) was also very important.</p> <ul style="list-style-type: none"> <li>• Location/place of delivery - own home.</li> </ul> <p><b>Comparison intervention:</b> Conventional home care service.</p> <p><b>Outcomes measured:</b> Service user related outcomes</p> <ul style="list-style-type: none"> <li>• Self-perceived health (a 5 point scale).</li> </ul>	<p>0.5533.</p> <p>Lives alone: No: d=0.1886; 95% CI -0.037 to 0.4142; Yes: d=0.0445; 95% CI -0.1185 to 0.2076.</p> <p>Owner occupier: No: d=0.1186; 95% CI -0.0826 to 0.3199; Yes: d=0.0536; 95% CI -0.1282 to 0.2353.</p> <p>Informal carer in same household: No: d=0.089; 95% CI -0.0678 to 0.2458; Yes: d=0.1525; 95% CI -0.0966 to 0.4017.</p> <p>Informal carer in another household: No: d=0.1972; 95% CI -0.0226 to 0.4169; Yes: d=0.0623; 95% CI -0.1041 to 0.2288.</p> <p>FACS (Fair Access to Care Services) level: Critical or substantial: d=0.4242; 95% CI 0.1966 to 0.6517; Moderate or low: d=-0.3097; 95% CI -0.5773 to -0.0421.</p> <p>Perceived quality of life by sample characteristics and dependency at follow-up</p> <p>Age: Under 65 years:</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Perceived quality of life (a 7 point scale).</li> <li>• Health-related quality of life (EQ-5D – Euro-QoL).</li> <li>• Social care outcomes (ASCOT – Adult Social Care Outcomes Toolkit). For service users’ outcomes, all questionnaires were administered by interviewers.</li> </ul> <p>Satisfaction with services - Service users and their informal carers were interviewed in-depth about their views of the reablement service, to explore the factors which influenced reablement progress and outcomes. Also, unpaid carers' experiences of helping service users and the impact of home care reablement service on the care-giving role were sought.</p> <p>Service outcomes Use of health care, equipment, social care and other services</p>	<p>d=0.717; 95% CI -0.1339 to 1.568.</p> <p>Over 65 years: d=0.2635; 95% CI 0.0452 to 0.4819.</p> <p>Gender: Male: d=0.2577; 95% CI -0.1328 to 0.6482; Female: d=0.3121; 95% CI 0.0621 to 0.5621.</p> <p>Ethnicity: White British or Irish: d=0.3088; 95% CI 0.0913 to 0.5263; Other: d=-0.0352; 95% CI -0.9674 to 0.897.</p> <p>Lives alone: No: d=0.2396; 95% CI -0.1411 to 0.6204; Yes: d=0.3012; 95% CI 0.0508 to 0.5516.</p> <p>Owner occupier: No: d=0.2774; 95% CI -0.0607 to 0.6154; Yes: d=0.3066; 95% CI 0.037 to 0.5761.</p> <p>Informal carer in same household: No: d=0.3864; 95% CI 0.1393 to 0.6335; Yes: d=0.0189; 95% CI -0.3751 to 0.4129.</p> <p>Informal carer in another household: No: d=0.4297; 95% CI 0.1176 to 0.7418;</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>(assessed by postal questionnaires).</p> <p><b>Follow-up:</b> Follow-up took place at 9 to 12 months post intervention.</p> <p><b>Costs?</b> Economic evaluation - full or partial. The economic evaluation conducted as part of this study will be reviewed by the team economist.</p>	<p>Yes: <math>d=0.1714</math>; 95% CI -0.1105 to 0.4534.</p> <p>Health-related quality of life (EQ-5D) by sample characteristics and dependency at baseline</p> <p>Age: Under 65 years: <math>d=0.1925</math>; 95% CI -0.6673 to 1.0524.</p> <p>Over 65 years: <math>d=-0.0312</math>; 95% CI -0.2484 to 0.1861.</p> <p>Gender: Male: <math>d=-0.0785</math>; 95% CI -0.4663 to 0.3094; Female: <math>d=-0.0099</math>; 95% CI -0.2593 to 0.2395.</p> <p>Ethnicity: White British or Irish: <math>d=-0.0103</math>; 95% CI -0.2264 to 0.2059; Other: <math>d=-0.2104</math>; 95% CI -1.1605 to 0.7397.</p> <p>Lives alone: No: <math>d=-0.021</math>; 95% CI -0.4006 to 0.3585; Yes: <math>d=-0.0501</math>; 95% CI -0.2997 to 0.1995.</p> <p>Owner occupier: No: <math>d=-0.0526</math>; 95% CI -0.3896 to 0.2844; Yes: <math>d=0.02</math>; 95% CI -0.2482 to 0.2882.</p> <p>Informal carer in same</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>household: No: d=0.01; 95% CI -0.2355 to 0.2554; Yes: d=-0.1876; 95% CI -0.5823 to 0.2072.</p> <p>Informal carer in another household: No: d=0.157; 95% CI -0.1531 to 0.4672; Yes: d=-0.2333; 95% CI -0.5156 to 0.049.</p> <p>Perceived quality of life by sample characteristics and dependency at baseline:</p> <p>Age: Under 65 years: d=0.1414; 95% CI -0.3397 to 0.6224; Over 65 years: d=0.1596; 95% CI 0.0226 to 0.2967.</p> <p>Gender: Male: d=0.0941; 95% CI -0.1427 to 0.3308; Female: d=0.155; 95% CI -0.0023 to 0.3122.</p> <p>Ethnicity: White British or Irish: d=0.1857; 95% CI 0.0481 to 0.3233; Other: d=-0.5338; 95% CI -0.9846 to -0.083.</p> <p>Lives alone: No: d=0.3206; 95% CI -0.037 to 0.4142; Yes: d=0.031; 95% CI</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>-0.1296 to 0.1916.  Owner occupier: No: d=0; 95% CI -0.1977 to -0.1977; Yes: d=0.2795; 95% CI 0.0976 to 0.4614.  Informal carer in same household: No: d=0; 95% CI -0.1553 to -0.1553; Yes: d=0.4991; 95% CI 0.2502 to 0.748.  Informal carer in another household: No: d=0.1837; 95% CI -0.0334 to 0.4008; Yes: d=0.1256; 95% CI -0.0393 to 0.2905.</p> <p>Effect size of costs (£s), with imputed missing values  Social care ten months: d=-0.5522; 95% CI -0.7085 to -0.3958.  Total social care costs (12 months): d=-0.1322; 95% CI -0.286 to 0.0216.  Health costs 8 weeks: d=0.2404; 95% CI 0.0863 to 0.3946.  Health costs ten months: d=0.0771; 95% CI -0.0766 to</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>0.2308. Total costs (12 months): d=0.0584; 95% CI -0.0953 to 0.212.</p> <p><b>Narrative findings - service user related outcomes - Perceived health</b> A smaller percentage of people in the re-ablement group than in the comparison group perceived their health to have improved and a greater percentage felt it had declined.</p> <p>Perceived quality of life 'In the reablement group, there was a statistically significant deterioration in the mean score for perceived health by the time of 12 month follow-up (baseline mean 3.24 (SD 0.91); follow-up mean 2.94 (SD 0.99); p&lt;0.001). In the comparison group, there was no change in mean perceived health from a baseline score of 2.99</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>(standard deviation 0.99) to a 12 month follow-up score of 2.96 (SD 1.04)' (p71).</p> <p>Health related quality of life Overall, use of reablement was statistically significantly associated with better EQ-5D outcomes than the use of conventional home care services. The net effect of using reablement services in this analysis was around 0.1 on the EQ-5D scale (which runs from a score of 1 for full health to -0.5). The result is significant with a CI of 0.02 to 0.18.</p> <p>Social care related quality of life Mean ASCOT scores for people in the reablement and comparison groups at baseline and follow up show a very small improvement for the reablement group (+0.03) over the comparison group (+0.02), before adjustment for</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>baseline differences and time effects.</p> <p><b>Narrative findings - qualitative and views and experiences data -</b>  Views of services users and their informal carers (qualitative data)  To avoid double counting, refer to Wilde and Glendinning (2012) for the findings from the interviews with people using reablement and their carers.</p> <p>Views of senior managers and front-line staff (qualitative data)  To avoid double counting, refer to Rabiee and Glendinning (2011) for the findings from the interviews with managers, observations of reablement visits and focus groups with front line staff involved in the organisation and delivery of reablement.</p>	

**3. Lewin G, Allan J, Patterson C et al. (2014) A comparison of the home-care and healthcare service use and costs of older Australians randomised to receive a restorative or a conventional homecare service. Health and Social Care in the Community 22: 328–36**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The study aimed to compare ‘... the health and aged care service use and costs of older home-care clients who were randomly assigned to receive either a restorative or conventional home-care service’ (p329).</p> <p><b>Country:</b> Australia – Perth metropolitan area.</p> <p><b>Methodology:</b> Randomised controlled trial.</p> <p><b>Source of funding:</b> Government - Australian Health Ministers’ Advisory Council.</p>	<p><b>Participants:</b> Service users and their families, partners and carers - Individuals were eligible for the service/trial if they were aged 65 years or more, lived in the Perth metropolitan area (as the intervention was not provided in rural areas), had been assessed as eligible for personal care funded by the government Home and Community Care programme as a result of ongoing difficulties in activities of daily living (rather than a need for post-acute care), were English speakers, and did not have a diagnosis of dementia or terminal illness. Individuals were also excluded if they had complex support needs for which more than 15 hours per week of home care was required.</p>	<p>NB. Effect sizes not presented by authors. Effect sizes presented here were calculated by the review team.</p> <p><b>Statistical data – service outcomes -</b>            Service use in first year (intention-to-treat)            Hours of care (all services):            The intervention group used significantly fewer hours of care (all services) during the first year than the control group; control (n=375) mean 116.8 (125.4 SD); intervention (n=375) mean 83.6 (81.9 SD); p&lt;0.001.            Hours of care (personal care only): The intervention group used significantly fewer hours of care (personal care only) during the first year than the control group; control (n=375) mean 45.6 (49.3 SD);</p>	<p><b>Overall assessment of internal validity:</b> -  A key limitation of the study is the possibility that the randomisation process may have been compromised and it is therefore difficult to apply a higher quality rating.</p> <p><b>Overall assessment of external validity:</b> ++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age – Intention to treat/randomised – control mean age = 82.7 years (7.7 SD); intervention mean age = 81.8 years (7.2 SD); p=0.105. Age - As treated - control mean age = 82.7 years (7.6 SD); intervention mean age = 81.9 years (7.4 SD); p=0.164.</li> <li>• Sex – Intention to treat/randomised – control female n=242 (64.5%); intervention female n=263 (70.1%); p=0.102. Sex - As treated – control female n=254 (64.3%); intervention female n=224 (72.3%) p=0.025.</li> <li>• Ethnicity – Not reported however details on country of birth are provided. Born in Australia - Intention to treat/randomised – control – n=183 (48.8%); intervention n=204 (54.4%); p=0.415. Born in Australia - As treated – control n=195 (49.4%);</li> </ul>	<p>intervention (n=375) mean 19.1 (27.6 SD); p&lt;0.001. Assessed and approved for higher level of care: A significantly lower proportion of participants in the intervention group were assessed and approved for a higher level of care during the first year compared to that in the control group; control (n=375) n=190 (50.7%); intervention (n=375) n=163 (43.5%); p=0.048. Ongoing personal care: A significantly lower proportion of participants in the intervention group were receiving ongoing personal care at the first year follow-up compared to that in the control group; control (n=310) n=160 (51.6%); intervention (n=150) n=63 (25.2%); p&lt;0.001. Emergent personal care: A significantly lower proportion of participants in the intervention group were in</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>intervention n=173 (55.8%); p=0.211.</p> <ul style="list-style-type: none"> <li>• Religion/belief - Not reported.</li> <li>• Disability - Not reported.</li> <li>• Long term health condition - Not reported.</li> <li>• Socioeconomic position –</li> <li>• Has carer - Intention to treat/randomised – control n=254 (67.7%); intervention n=216 (57.6%); p=0.004. Has carer - As treated – control n=266 (67.3%); intervention n=176 (56.8%); p=0.004.</li> <li>• Co-resident carer - Intention to treat/randomised – control n=185 (72.8%); intervention n=141 (65.6%); p=0.089. Co-resident carer - As treated – control n=195 (73.3%); intervention n=109 (62.3%); p=0.014.</li> <li>• Lived alone - Intention to treat/randomised – control n=159 (42.4%); n=192 (51.2%); p=0.016. Lived</li> </ul>	<p>receipt of a new personal care service at the first year follow-up compared to that in the control group; control (n=65) n=18 (27.7%); intervention (n=125) n=17 (13.6%); p=0.017.</p> <p>Emergency department presentation: A lower proportion of participants in the intervention group presented to the emergency department during the first year compared to that in the control group however this difference was not statistically significant; control (n=375) n=208 (55.5%); intervention (n=375) n=188 (50.1%); p=0.143.</p> <p>Hospital admission: A lower proportion of participants in the intervention group were admitted to hospital during the first year compared to that in the control group however this difference was not statistically significant; control (n=375) n=218</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>alone - As treated – control n=167 (42.3%); n=164 (52.9%); p=0.005.</p> <ul style="list-style-type: none"> <li>• Government pension - Intention to treat/randomised – control n=350 (93.3%); intervention n=333 (88.8%); p=0.097. Government pension - As treated – control n=367 (92.9%); intervention n=276 (89.0%); p=0.207.</li> </ul> <p><b>Baseline characteristics:</b></p> <ul style="list-style-type: none"> <li>• Activities of Daily Living Silver Chain – Intention to treat/randomised – control mean score 12.2 (3.2 SD); intervention mean score 12.8 (2.8 SD); p=0.013. Activities of Daily Living Silver Chain – As treated – control mean score 12.2 (3.1 SD); intervention mean score 12.9 (2.7 SD); p=0.005.</li> <li>• Instrumental Activities of Daily Living Silver Chain – Intention to treat/randomised – control mean score 7.2</li> </ul>	<p>(58.1%); intervention (n=375) n=206 (54.9%); p=0.377. Episodic length of stay: Participants in the intervention group who were admitted to hospital during the first year (unplanned) had a shorter length of stay (episodic) compared to those in the control group however this difference was not statistically significant; control (n=375) mean 6.3 (9.9 SD); intervention (n=375) mean 5.4 (9.2 SD); p=0.092. Cumulative length of stay: Participants in the intervention group who were admitted to hospital during the first year (unplanned) had shorter lengths of stay (cumulative) compared to those in the control group however this difference was not statistically significant; control (n=375) mean 18.6 (19.0 SD); intervention (n=375) mean 18.4 (24.2 SD); p=0.926.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>(3.6 SD); intervention mean score 8.1 (3.2 SD); <math>p &lt; 0.001</math>. Instrumental Activities of Daily Living Silver Chain – As treated – control mean score 7.2 (3.7 SD); intervention mean score 8.2 (3.1 SD) <math>p &lt; 0.001</math>.</p> <p><b>Service use in the previous year:</b></p> <ul style="list-style-type: none"> <li>• Home and Community Care programme care (all services) - Intention to treat/randomised – control mean 49.22 hours (45.43 SD); intervention mean 45.09 hours (47.35 SD); <math>p = 0.437</math>. Home and Community Care programme care (all services) – As treated – control mean 49.55 hours (47.17 SD); intervention mean 46.65 hours (45.50 SD); <math>p = 0.287</math>.</li> <li>• Home and Community Care programme (personal care) - Intention to treat/randomised – control mean 33.37 hours</li> </ul>	<p>Deaths, observed (expected): There was no significant difference between the intervention or control groups in the difference between the observed rate of death and the expected rate of death; (control <math>n = 77</math> (<math>n = 75.8</math>) vs. intervention <math>n = 74</math> (<math>n = 75.2</math>); <math>p = 0.840</math>.</p> <p>Service use in first year (as treated) Hours of care (all services): The intervention group used significantly fewer hours of care (all services) during the first year than the control group; control (<math>n = 395</math>) mean 119.6 (124.9 SD); intervention (<math>n = 310</math>) mean 79.5 (70.6 SD); <math>p &lt; 0.001</math>. Hours of care (personal care only): The intervention group used significantly fewer hours of care (personal care only) during the first year than the control group; control (<math>n = 395</math>) mean 48.2 (49.1 SD);</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>(36.20 SD); intervention mean 24.94 hours (34.14 SD); <math>p=0.486</math>. Home and Community Care programme (personal care) - As treated – control mean 39.40 hours (39.80 SD); intervention mean 17.27 hours (25.47 SD); <math>p=0.108</math>.</p> <ul style="list-style-type: none"> <li>• Ongoing personal care - Intention to treat/randomised – control <math>n=23</math> (6.13%); intervention <math>n=6</math> (1.60%); <math>p = 0.02</math>. Ongoing personal care – As treated – control <math>n=24</math> (6.07%); intervention <math>n=3</math> (0.97%); <math>p=0.001</math>.</li> <li>• Emergency department presentation - Intention to treat/randomised – control <math>n=198</math> (52.80%); intervention <math>n=201</math> (53.60%); <math>p=0.826</math>. Emergency department presentation – As treated – control <math>n=209</math> (52.91%); intervention <math>n=162</math> (52.26%); <math>p=0.863</math>.</li> <li>• Hospital admission - Intention to treat/randomised</li> </ul>	<p>intervention (<math>n=310</math>) mean 16.1 (22.2 SD); <math>p&lt;0.001</math>. Assessed and approved for higher level of care: A lower proportion of participants in the intervention group were assessed and approved for a higher level of care during the first year compared to that in the control group however this difference was not statistically significant; control (<math>n=395</math>) <math>n=196</math> (49.6%); intervention (<math>n=310</math>) <math>n=134</math> (43.2%); <math>p=0.091</math>. Ongoing personal care: A significantly lower proportion of participants in the intervention group were receiving ongoing personal care at the first year follow-up compared to that in the control group; control (<math>n=336</math>) <math>n=175</math> (52.1%); intervention (<math>n=216</math>) <math>n=45</math> (20.8%); <math>p&lt;0.001</math>. Emergent personal care: A significantly lower proportion of participants in the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>– control n=224 (59.73%); intervention n=215 (57.33%); p=0.505. Hospital admission - As treated – control n=232 (58.73%); intervention n=176 (56.77%); p=0.601.</p> <ul style="list-style-type: none"> <li>• Episodic length of stay - Intention to treat/randomised – control mean 9.21 (12.79 SD); intervention mean 9.80 (11.40 SD); p=0.493. Episodic length of stay - As treated – control mean 9.14 (12.50 SD); intervention mean 10.08 (12.11 SD); p=0.302.</li> <li>• Cumulative length of stay - Intention to treat/randomised – control mean 10.51 (19.00 SD); intervention 9.83 (17.09 SD); p=0.605. Cumulative length of stay - As treated – control mean 10.71 (19.04 SD); 9.79 (17.60 SD); p=0.511.</li> </ul> <p><b>Sample size:</b></p>	<p>intervention group were in receipt of a new personal care service at the first year follow-up compared to that in the control group; control (n=59) n=22 (37.3%); intervention (n=94) n=11 (11.7%); p&lt;0.001. Emergency department presentation: A significantly lower proportion of participants in the intervention group presented to the emergency department during the first year compared to that in the control group; control (n=395) n=224 (56.7%); intervention (n=310) n=146 (47.1%); p=0.011. Hospital admission: A significantly lower proportion of participants in the intervention group were admitted to hospital during the first year compared to that in the control group; control (n=395) n=233</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Comparison numbers – Intention to treat/randomised n=375; as treated n=395.</li> <li>• Intervention numbers – Intention to treat/randomised n=375; as treated n=310.</li> <li>• Sample size – Intention to treat/randomised N=750; as treated n=705.</li> </ul> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Description - The intervention is described as a restorative home care service.</li> <li>• Delivered by - The service is delivered by a not-for profit care provider named Silver Chain which is based in Western Australia. No details on the background or training level of staff are reported by the authors.</li> <li>• Delivered to - Participants were over the age of 65 and had been assessed as eligible for personal care funded by the government</li> </ul>	<p>(59.0%); intervention (n=310) n=160 (51.6%); p=0.050.</p> <p>Episodic length of stay: Participants in the intervention group who were admitted to hospital during the first year (unplanned) had a shorter length of stay (episodic) compared to those in the control group however this difference was not statistically significant; control (n=395) mean 6.1 (9.5 SD); intervention (n=310) mean 5.2 (9.1 SD); p=0.109.</p> <p>Cumulative length of stay: Participants in the intervention group who were admitted to hospital during the first year (unplanned) had longer lengths of stay (cumulative) compared to those in the control group however this difference was not statistically significant; control (n=395) mean 18.3 (18.9 SD); intervention (n=310) mean 19.11 (26.0 SD); p=0.708.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>Home and Community Care programme as a result of ongoing difficulties in activities of daily living (rather than a need for post-acute care). Eligibility was also restricted to individuals residing in the Perth metropolitan area who could speak English and did not have a diagnosis of dementia or terminal illness. Individuals with complex support needs requiring more than 15 hours per week of home care were excluded.</p> <ul style="list-style-type: none"> <li>• Duration, frequency, intensity, etc. - The authors report that the service is usually provided for up to 12 weeks however no further details on frequency or intensity are provided.</li> <li>• Key components and objectives of intervention - The intervention is described as a goal-oriented, individualised programme</li> </ul>	<p>Deaths, observed (expected): There was no significant difference between the intervention or control groups in the difference between the observed rate of death and the expected rate of death; control n=84 (n=79.9) vs. intervention n=59 (n=63.1); p=0.489.</p> <p>Service use in second year (intention-to-treat) Hours of care (all services): The intervention group used significantly fewer hours of care (all services) during the second year than the control group; control (n=298) mean 92.5 (137.9 SD); intervention (n=301) mean 50.4 (90.7 SD); p&lt;0.001.</p> <p>Hours of care (personal care only): The intervention group used significantly fewer hours of care (personal care only) during the second year than the control group; control (n=298) mean 36.2 (51.5</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>that is designed to foster independence and reduce the need for ongoing care. Engagement in activities of daily living is encouraged through the use of ‘... task analysis and redesign, work simplification and assistive technology’ (p330). The programme can be modified to according to the service user goals and can include techniques to improve mobility (by incorporating balance, endurance, and strength components); and strategies to enable self-management of chronic disease, prevention of falls, management of continence, medicine and nutrition, and development of social networks.</p> <ul style="list-style-type: none"> <li>• Location/place of delivery - The service is provided in the participant’s own home.</li> </ul> <p><b>Comparison intervention:</b> Care as usual. Individuals</p>	<p>SD); intervention (n=301) mean 13.4 (31.5 SD); p&lt;0.001.</p> <p>Assessed and approved for higher level of care: A lower proportion of participants in the intervention group were assessed and approved for a higher level of care during the second year compared to that in the control group however this difference was not statistically significant; control (n=298) n=104 (34.9%); intervention (n=301) n=92 (30.6%); p=0.258.</p> <p>Ongoing personal care: A significantly lower proportion of participants in the intervention group were receiving ongoing personal care at the second year follow-up compared to that in the control group; control (n=246) n=85 (34.5%); intervention (n=201) n=23 (11.4%); p&lt;0.001.</p> <p>Emergent personal care: A significantly lower proportion</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>randomised to the control group received a telephone assessment by a care co-ordinator who devised a care plan and arranged support accordingly. The authors report that the ‘... most common care plan included 3 personal care visits a week to assist with bathing/showering and fortnightly domestic assistance to clean and do the heavy laundry. Social support and in-home or centre-based respite were also available, although used less commonly’ (p330).</p> <p><b>Outcomes measured:</b> Data were collected (using the Western Australia Data Linkage System) in relation to -</p> <ul style="list-style-type: none"> <li>• Hours of care (all services).</li> <li>• Hours of care (personal care only).</li> <li>• Participants assessed and approved for higher level of care.</li> <li>• Receipt of an ongoing personal care.</li> </ul>	<p>of participants in the intervention group were in receipt of a new personal care service at the second year follow-up compared to that in the control group; control (n=52) n=9 (17.3%); intervention (n=100) n=6 (6.0%); p=0.027.</p> <p>Emergency department presentation: A lower proportion of participants in the intervention group presented to the emergency department during the second year compared to that in the control group however this difference was not statistically significant; control (n=298) n=139 (46.6%); intervention (n=301) n=117 (38.9%); p=0.054.</p> <p>Hospital admission: A lower proportion of participants in the intervention group were admitted to hospital during the second year compared to that in the control group however this difference was</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Emergent personal care service.</li> <li>• Emergency department presentations.</li> <li>• Hospital admissions (unplanned).</li> <li>• Episodic lengths of stay (resulting from an unplanned hospital admission).</li> <li>• Cumulative length of stay (resulting from unplanned hospital admissions).</li> <li>• Deaths, observed (expected).</li> </ul> <p>Costs were assessed by combining the costs of aged care and health care. Aged care included costs arising from Home and Community Care programme care. Health care included costs arising from emergency department presentations and hospital admissions.</p>	<p>not statistically significant; control (n=298) n=132 (44.3%); intervention (n=301) n=110 (36.5%); p=0.053.</p> <p>Episodic length of stay: Participants in the intervention group who were admitted to hospital during the second year (unplanned) had a shorter length of stay (episodic) compared to those in the control group however this difference was not statistically significant; control (n=298) mean 4.4 (9.9 SD); intervention (n=301) mean 3.9 (10.4 SD) p=0.301.</p> <p>Cumulative length of stay: Participants in the intervention group who were admitted to hospital during the second year (unplanned) had longer lengths of stay (cumulative) compared to those in the control group however this difference was not statistically significant; control (n=298) mean 15.2 (15.4 SD); intervention</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p><b>Follow-up:</b> Data were collected over the course of 2 years.</p> <p><b>Costs?</b> Economic evaluation – full or partial. Please read these findings in conjunction with economic evidence tables.</p>	<p>(n=301) mean 20.6 (27.6 SD); p=0.055.</p> <p>Deaths, observed (expected): There was a significant difference between the intervention and control groups in the difference between the observed rate of death and the expected rate of death; control n=62 (SD=51.2) vs. intervention n=43 (SD=53.8); p=0.035.</p> <p>Service use in second year (as treated). Hours of care (all services): The intervention group used significantly fewer hours of care (all services) during the second year than the control group; control (n=311) mean 90.8 (138.7 SD); intervention (n=251) mean 46.7 (75.8 SD); p&lt;0.001. Hours of care (personal care only): The intervention group used significantly fewer hours of care (personal care only) during the second year than</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>the control group; control (n=311) mean 37.9 (52.9 SD); intervention (n=251) mean 11.0 (26.2 SD); p&lt;0.001.</p> <p>Assessed and approved for higher level of care: A lower proportion of participants in the intervention group were assessed and approved for a higher level of care during the second year compared to that in the control group however this difference was not statistically significant; control (n=311) n=110 (35.4%); intervention (n=251) n=73 (29.1%); p=0.114.</p> <p>Ongoing personal care: A significantly lower proportion of participants in the intervention group were receiving ongoing personal care at the second year follow-up compared to that in the control group; control (n=266) n=85 (31.9%); intervention (n=174) n=20 (11.5%); p&lt;0.001.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Emergent personal care: A significantly lower proportion of participants in the intervention group were in receipt of a new personal care service at the second year follow-up compared to that in the control group; control (n=45) n=10 (22.2%); intervention (n=77) n=4 (5.2%); p=0.004.</p> <p>Emergency department presentation: A significantly lower proportion of participants in the intervention group presented to the emergency department during the second year compared to that in the control group; control (n=311) n=143 (46.0%); intervention (n=251) n=94 (37.4%); p=0.042.</p> <p>Hospital admission: A significantly lower proportion of participants in the intervention group were admitted to hospital during the second year compared to</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>that in the control group; control (n=311) n=139 (44.7%); intervention (n=251) n=87 (34.66%); p=0.016.</p> <p>Episodic length of stay: Participants in the intervention group who were admitted to hospital during the second year (unplanned) had a shorter length of stay (episodic) compared to those in the control group however this difference was not statistically significant; control (n=311) mean 4.5 (10.1 SD); intervention (n=251) mean 3.9 (10.8 SD); p=0.235.</p> <p>Cumulative length of stay: Participants in the intervention group who were admitted to hospital during the second year (unplanned) had significantly longer lengths of stay (cumulative) compared to those in the control group; control (n=311) mean 15.7 (16.2 SD); intervention (n=251) mean 21.8 (29.1 SD); p=0.044.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Deaths, observed (expected): There was a significant difference between the intervention and control groups in the difference between the observed rate of death and the expected rate of death; control n=66 (n=53.7) vs. intervention n=33 (n=45.3); p=0.013.</p> <p>Overall service use in 24 month period (intention-to-treat) -  Hours of care (all services): The intervention group used significantly fewer hours of care (all services) over the 2 year follow-up period than the control group; control (n=375) mean 190.3 (230.4 SD); intervention (n=375) mean 124.0 (154.5 SD); p&lt;0.001.  Hours of care (personal care only): The intervention group used significantly fewer hours of care (personal care only) over the 2 year follow-up period than the control group;</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>control (n=375) mean 74.4 (86.6 SD); intervention (n=375) mean 29.8 (52.6 SD); p&lt;0.001.</p> <p>Assessed and approved for higher level of care: A significantly lower proportion of participants in the intervention group were assessed and approved for a higher level of care over the 2 year follow-up period compared to that in the control group; control (n=375) n=241 (64.3%); intervention (n=375) n=210 (56.0%); p=0.021.</p> <p>Emergency department presentation: A lower proportion of participants in the intervention group presented to the emergency department over the 2 year follow-up period compared to that in the control group however this difference was not statistically significant; control (n=375) n=257</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>(68.5%); intervention (n=375) n=239 (63.7%); p=0.165.  Hospital admission: A lower proportion of participants in the intervention group were admitted to hospital over the 2 year follow-up period compared to that in the control group however this difference was not statistically significant; control (n=375) n=265 (70.7%); intervention (n=375) n=248 (66.1%); p=0.182.  Episodic length of stay: Participants in the intervention group who were admitted to hospital over the 2 year period (unplanned) had a shorter length of stay (episodic) compared to those in the control group however this difference was not statistically significant; control (n=375) mean 7.6 (10.9 SD); intervention (n=375) mean 6.8 (10.5 SD); p=0.161.  Cumulative length of stay: Participants in the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>intervention group who were admitted to hospital over the 2 year period (unplanned) had longer lengths of stay (cumulative) compared to those in the control group however this difference was not statistically significant; control (n=375) mean 22.8 (22.8 SD); intervention (n=375) mean 24.4 (36.4 SD); p=0.558.</p> <p>Deaths, observed (expected): There was no significant difference between the intervention and control groups in the difference between the observed rate of death and the expected rate of death; control n=139 (n=127) vs. intervention n=117 (n=129); p=0.133.</p> <p>Overall service use in 24 month period (as treated) Hours of care (all services): The intervention group used significantly fewer hours of care (all services) over the 2</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>year follow-up period than the control group; control (n=395) mean 191.2 (230.4 SD); intervention (n=310) mean 117.3 (129.4 SD); p&lt;0.001.</p> <p>Hours of care (personal care only): The intervention group used significantly fewer hours of care (personal care only) over the 2 year follow-up period than the control group; control (n=395) mean 78.0 (87.9 SD); intervention (n=310) mean 25.0 (42.4 SD); p&lt;0.001.</p> <p>Assessed and approved for higher level of care: A significantly lower proportion of participants in the intervention group were assessed and approved for a higher level of care over the 2 year follow-up period compared to that in the control group; control (n=395) n=249 (63.0%); intervention (n=310) n=171 (55.2%); p=0.034.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Emergency department presentation: A significantly lower proportion of participants in the intervention group presented to the emergency department over the 2 year follow-up period compared to that in the control group; control (n=395) n=274 (69.4%); intervention (n=310) n=188 (60.6%); p=0.016.</p> <p>Hospital admission: A significantly lower proportion of participants in the intervention group were admitted to hospital over the 2 year follow-up period compared to that in the control group; control (n=395) n=283 (71.6%); intervention (n=310) n=194 (62.6%); p=0.011.</p> <p>Episodic length of stay: Participants in the intervention group who were admitted to hospital over the 2 year period (unplanned) had a shorter length of stay</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>(episodic) compared to those in the control group however this difference was not statistically significant; control (n=395) mean 7.5 (10.7 SD); intervention (n=310) mean 6.6 (10.4 SD); p=0.120.</p> <p>Cumulative length of stay: Participants in the intervention group who were admitted to hospital over the 2 year period (unplanned) had longer lengths of stay (cumulative) compared to those in the control group however this difference was not statistically significant; control (n=395) mean 22.8 (23.3 SD); intervention (n=310) mean 25.55 (39.5 SD); p=0.335.</p> <p>Deaths, observed (expected): There was a significant difference between the intervention and control groups in the difference between the observed rate of death and the expected rate of death; control n=150</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>(n=133.6) vs. intervention n=92 (n=108.4); p=0.034.</p> <p>Adjusted odds of emergency department presentation and hospital admission during the first year, intervention vs. control (intention-to-treat, n=748, adjusted for carer status, dependency, gender and living arrangements) –  Emergency department presentation: Participants in the intervention group were less likely to present to an emergency department during the first year than those in the control group however this result was not statistically significant; odds ratio = 0.83 (95% Confidence Interval 0.62 to 1.11); p=0.206.  Hospital admission: Participants in the intervention group were less likely to be admitted to hospital during the first year (unplanned) than those in the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>control group however this result was not statistically significant; odds ratio = 0.93 (95% CI 0.69 to 1.26); p=0.650.</p> <p>Adjusted odds of emergency department presentation and hospital admission during the first year, intervention vs. control (as treated, n=704 adjusted for carer status, dependency, gender and living arrangements)</p> <p>Emergency department presentation: Participants in the intervention group were less likely to present to an emergency department during the first year than those in the control group. This result was statistically significant; odds ratio = 0.70 (95% CI 0.52 to 0.95); p=0.023.</p> <p>Hospital admission: Participants in the intervention group were less likely to be admitted to</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>hospital during the first year (unplanned) than those in the control group however this result was not statistically significant; odds ratio = 0.79 (95% CI 0.58 to 1.07); p=0.130.</p> <p>Adjusted odds of emergency department presentation and hospital admission during the second year, intervention vs. control (intention-to-treat, n=598, adjusted for carer status, dependency, gender and living arrangements)  Emergency department presentation: Participants in the intervention group were less likely to present to an emergency department during the second year than those in the control group however this result was not statistically significant; odds ratio = 0.72 (95% CI 0.52 to 1.01); p=0.056.  Hospital admission:  Participants in the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>intervention group were less likely to be admitted to hospital during the second year (unplanned) than those in the control group however this result was not statistically significant; odds ratio = 0.74 (95% CI 0.53 to 1.03); p=0.073.</p> <p>Adjusted odds of emergency department presentation and hospital admission during the second year, intervention vs. control (as treated, n=562, adjusted for carer status, dependency, gender and living arrangements) – Emergency department presentation: Participants in the intervention group were less likely to present to an emergency department during the second year than those in the control group. This result was statistically significant; odds ratio = 0.70 (95% CI 0.49 to 0.99); p=0.045.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Hospital admission: Participants in the intervention group were less likely to be admitted to hospital during the second year (unplanned) than those in the control group. This result was statistically significant; odds ratio = 0.66 (95% CI 0.46 to 0.94); p=0.020.</p> <p>Adjusted odds of emergency department presentation and hospital admission over 24 month follow-up period, intervention vs. control (intention-to-treat, n=748, adjusted for carer status, dependency, gender and living arrangements) – Emergency department presentation: Participants in the intervention group were less likely to present to an emergency department over the 24 month follow-up period than those in the control group however this result was</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>not statistically significant; odds ratio = 0.81 (95% CI 0.60 to 1.10); p=0.183.</p> <p>Hospital admission: Participants in the intervention group were less likely to be admitted to hospital (unplanned) over the 24 month follow-up period than those in the control group however this result was not statistically significant; odds ratio = 0.85 (95% CI 0.62 to 1.17); p=0.316.</p> <p>Adjusted odds of emergency department presentation and hospital admission over 24 month follow-up period, intervention vs. control (as treated, n=704, adjusted for carer status, dependency, gender and living arrangements)</p> <p>Emergency department presentation: Participants in the intervention group were less likely to present to an emergency department over</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>the 24 month follow-up period than those in the control group. This result was statistically significant; odds ratio = 0.69 (95% CI 0.50 to 0.94); p=0.021.</p> <p>Hospital admission: Participants in the intervention group were less likely to be admitted to hospital (unplanned) over the 24 month follow-up period than those in the control group. This result was statistically significant; odds ratio = 0.69 (95% CI 0.50 to 0.95); p=0.025.</p> <p>Effect sizes In this study, randomisation was compromised, so the research report presented both Intention to Treat (ITT, randomised) data, and Actual Treatment (AT, non-randomised) data, about outcomes over time. LOS = Episodic length of stay. First year:</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Hours of all services ITT: d=-0.3135; 95% CI -0.4575 to -0.1695.</p> <p>Hours personal care ITT: d=-0.6633; 95% CI -0.8103 to -0.5163.</p> <p>Episodic LOS ITT: d=-0.0942; 95% CI -0.2374 to 0.049.</p> <p>Cumulative LOS ITT: d=-0.0092; 95% CI -0.1523 to 0.1339.</p> <p>Hours of all services AT: d=-0.3835; 95% CI -0.5336 to -0.2334.</p> <p>Hours of personal care AT: d=-0.8107; 95% CI -0.9653 to -0.6561.</p> <p>Episodic LOS AT: d=-0.0965; 95% CI -0.2453 to 0.0523.</p> <p>Cumulative LOS AT: d=0.0363; 95% CI -0.1124 to 0.1851.</p> <p>Second year: Hours of all services ITT: d=-0.3611; 95% CI -0.5225 to -0.1996.</p> <p>Hours personal care ITT: d=-0.3836; 95% CI -0.5514 to -0.2158.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Episodic LOS ITT: <math>d=-0.0492</math>; 95% CI <math>-0.2094</math> to <math>0.111</math>.</p> <p>Cumulative LOS ITT: <math>d=0.2413</math>; 95% CI <math>0.0806</math> to <math>0.4021</math>.</p> <p>Hours of all services AT: <math>d=-0.5347</math>; 95% CI <math>-0.6977</math> to <math>-0.3717</math>.</p> <p>Hours of personal care AT: <math>d=-0.6245</math>; 95% CI <math>-0.7947</math> to <math>-0.4542</math>.</p> <p>Episodic LOS AT: <math>d=-0.0576</math>; 95% CI <math>-0.2239</math> to <math>0.1087</math>.</p> <p>Cumulative LOS AT: <math>d=0.2667</math>; 95% CI <math>0.0996</math> to <math>0.4337</math>.</p> <p>Overall 24 months:</p> <p>Hours of all services ITT: <math>d=-0.338</math>; 95% CI <math>-0.4822</math> to <math>-0.1938</math>.</p> <p>Hours personal care ITT: <math>d=-0.6225</math>; 95% CI <math>-0.7691</math> to <math>0.4759</math>.</p> <p>Episodic LOS ITT: <math>d=-0.0748</math>; 95% CI <math>-0.2179</math> to <math>0.0684</math>.</p> <p>Cumulative LOS ITT: <math>d=0.0527</math>; 95% CI <math>-0.0905</math> to <math>0.1958</math>.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Hours of all services AT: d=-0.3836; 95% CI -0.5337 to -0.2336.</p> <p>Hours of personal care AT: d=-0.7407; 95% CI -0.8943 to -0.587.</p> <p>Episodic LOS AT: d=-0.0852; 95% CI -0.2339 to 0.0636;</p> <p>Cumulative LOS AT: d=0.0874; 95% CI -0.0614 to 0.2362.</p> <p>Costs Mean total cost per client of all emergency department visits over 24-month period: The mean total cost per client of all emergency department visits over the 24-month period was AU\$22 (intent to treat – intervention AU\$686 vs. control AU\$708) and AU\$67 (as treated – intervention AU\$659 vs. control AU\$726) lower for the intervention group than the control group.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Mean total cost per client of all hospital admissions over 24-month period: The mean total cost per client of all hospital admissions over the 24 month period was AU\$306 (intent to treat – intervention AU\$13,369 vs. control AU\$13,675) and AU\$1,300 (as treated – intervention AU\$12,860 vs. control AU\$14,160) lower for the intervention group than the control group.</p> <p>Aggregated home-care and health care costs ('aged care' costs were restricted to home-care costs) - Mean aggregated home-care and health care costs per client over the 24-month period: The mean aggregated home care and health care costs per client over the 24-month period were AU\$2,869 (intent to treat – intervention AU\$19,888 vs. control AU\$22,757) and AU\$4,338</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>(as treated – intervention AU\$19,090 vs. control AU\$23,428) lower for the intervention group than the control group.</p> <p>Generalised linear model regression of aggregated health and aged care costs over time (intention-to-treat, model variables are sample size and group, adjusted for carer status, dependency, gender and living arrangements)</p> <p>First year: The aggregated health and aged care costs of participants in the intervention group were less costly by a factor of 0.92 than those of participants in the control group during the first year. This result was not statistically significant; n=748; estimated relative reduction = 0.92 (95% CI 0.80 to 1.06); p=0.276.</p> <p>Second year: The aggregated health and aged care costs of</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>participants in the intervention group were less costly by a factor of 0.85 than those of participants in the control group during the second year. This result was not statistically significant; n=598; estimated relative reduction = 0.85 (95% CI 0.68 to 1.06); p=0.155.</p> <p>Over total 24 month follow-up period: The aggregated health and aged care costs of participants in the intervention group were less costly by a factor of 0.89 than those of participants in the control group over 24 months period. This result was not statistically significant; n=748; estimated relative reduction = 0.89 (95% CI 0.78 to 1.02); p=0.083.</p> <p>Generalised linear model regression of aggregated health and aged care costs over time (as treated, model variables are sample size and</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>group, adjusted for carer status, dependency, gender and living arrangements)</p> <p>First year: The aggregated health and aged care costs of participants in the intervention group were less costly by a factor of 0.82 than those of participants in the control group during the first year. This result was statistically significant; n=704; estimated relative reduction = 0.82 (95% CI 0.70 to 0.95); p=0.007.</p> <p>Second year: The aggregated health and aged care costs of participants in the intervention group were less costly by a factor of 0.86 than those of participants in the control group during the second year. This result was not statistically significant; n=562; estimated relative reduction = 0.86 (95% CI 0.68 to 1.08); p=0.197.</p> <p>Over total 24 month follow-up period: The aggregated</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		health and aged care costs of participants in the intervention group were less costly by a factor of 0.83 than those of participants in the control group over 24 months period. This result was statistically significant; n=704; estimated relative reduction = 0.83 (95% CI 0.72 to 0.96); p=0.010.	

**4. Lewin G, De San Miguel K, Knuiman M et al. (2013) A randomised controlled trial of the Home Independence Program, an Australian restorative home-care programme for older adults. Health and Social Care in the Community 21: 69-78**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> To ‘... test the effectiveness of the Home Independence Program (HIP), a restorative home care programme for adults ...’ (p69).</p> <p><b>Country:</b> Australia – Perth (suburbs).</p> <p><b>Methodology:</b> Randomised controlled trial.</p>	<p><b>Participants:</b> Service users and their families, partners and carers - Older people living in the Perth suburbs referred for home care services who were eligible to receive funding for care from the Home and Community Care programme (jointly funded by the state and commonwealth governments). Eligibility for funding is reported by the authors as</p>	<p><b>Statistical data - service outcomes -</b> Service outcomes at 3 months (intention to treat) Ongoing personal care – A lower proportion of participants in the intervention group required ongoing personal care compared to that in the control group; control n=238</p>	<p><b>Overall assessment of internal validity:</b> -</p> <p><b>Overall assessment of external validity:</b> ++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Source of funding:</b> Government - Australian Health Ministers' Advisory Council priority-driven research programme grant.</p>	<p>'...needing assistance with 1 or more tasks of daily living because of an ongoing disability, rather than needing acute or post-acute care ...' (p71).</p> <p>Individuals were eligible for the study if they were over the age of 65, had been referred for personal care, did not have a diagnosis of dementia or a progressive neurological disorder, were not receiving palliative care, and were able to communicate in English.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age – Intention to treat/randomised – control mean age = 82.73 years (7.70 SD); intervention mean age = 81.84 years (7.19 SD); p=0.105.</li> <li>• Age - As treated - control mean age = 82.68 years (7.55 SD); intervention mean age = 81.89 years (7.36 SD); p=0.164.</li> </ul>	<p>(63.5%), intervention n=103 (27.5%).</p> <p>No care required – A higher proportion of participants in the intervention group no longer required any care compared to that in the control group; control n=63 (16.8%), intervention n=166 (44.3%).</p> <p>Died - A lower proportion of participants in the intervention group had died compared to that in the control group; control n=25 (6.6%), intervention n=17 (4.5%).</p> <p>Residential care - A lower proportion of participants in the intervention group were residing in residential care compared to that in the control group; control n=21 (5.6%), intervention n=16 (4.2%).</p> <p>Other community service – There were no differences between the 2 groups in the proportion of participants who</p>	

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	<ul style="list-style-type: none"> <li>• Sex – Intention to treat/randomised – control male n=133 (35.5%), female n=242 (64.5%); intervention male n=112 (29.9%), female n=263 (70.1%); p=0.102.</li> <li>• Sex - As treated – control male n=141 (35.7%), female n=254 (64.3%); intervention male n=86 (27.7%), female n=254 (72.3%); p=0.025.</li> <li>• Ethnicity – Not reported however details on country of birth and language are provided.</li> <li>• Country of birth - Intention to treat/randomised – control – Australia n=183 (48.8%), England n=69 (18.4%), Italy n=18 (4.8%), other n=105 (28.0%); intervention – Australia n=204 (54.4%), England n=64 (17.1%), Italy n=19 (5.1%), other n=88 (23.4%); p=0.415.</li> <li>• Country of birth - As treated – control – Australia n=195 (49.4%), England n=72</li> </ul>	<p>were receiving another community service; control n=10 (2.7%), intervention n=10 (2.7%).</p> <p>Declined/terminated - A higher proportion of participants in the intervention group had declined or terminated care compared to that in the control group; control n=9 (2.4%), intervention n=30 (8.0%).</p> <p>Admitted to hospital - A higher proportion of participants in the intervention group had been admitted to hospital compared to that in the control group; control n=6 (1.6%), intervention n=24 (6.4%).</p> <p>Moved out of area - A lower proportion of participants in the intervention group had moved out of the area compared to that in the control group; control n=3</p>	

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	<p>(18.2%), Italy n=19 (4.8%), other n=109 (27.6%); intervention – Australia n=173 (55.8%), England n=56 (18.1%), Italy n=16 (5.2%), other n=65 (20.9%); p=0.211.</p> <ul style="list-style-type: none"> <li>• Language - Intention to treat/randomised – control – English n=351 (93.6%), non-English n=24 (6.4%); intervention – English n=362 (96.5%), non-English n=13 (13.5%); p=0.064.</li> <li>• Language - As treated – control – English n=369 (93.4%), non-English n=26 (6.6%); intervention – English n=301 (97.1%), non-English n=9 (2.9%); p=0.026.</li> <li>• Religion/belief - Not reported.</li> <li>• Disability - Not reported.</li> <li>• Long term health condition - Not reported.</li> <li>• Socioeconomic position –</li> </ul>	<p>(0.8%), intervention n=0 (0.0%).</p> <p>Hospice care - A higher proportion of participants in the intervention group had received hospice care compared to that in the control group; control n=0 (0.0%), intervention n=9 (2.4%).</p> <p>Service outcomes at 12 months (intention to treat)</p> <p>Ongoing personal care - A lower proportion of participants in the intervention group required ongoing personal care compared to that in the control group; control n=151 (40.3%), intervention n=67 (17.9%).</p> <p>No care required - A higher proportion of participants in the intervention group no longer required any care compared to that in the control group; control n=75</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Pension - Intention to treat/randomised – control – aged pension n=318 (85.5%), no government pension n=25 (6.7%), other government pension n=29 (7.8%); intervention – aged pension n=307 (81.9%), no government pension n=42 (11.2%), other government pension n=26 (6.9%); p=0.097.</li> <li>• Pension – As treated – control – aged pension n=334 (85.2%), no government pension n=28 (7.1%), other government pension n=30 (7.7%); intervention – aged pension n=253 (81.6%), no government pension n=34 (11.0%), other government pension n=23 (7.4%); p=0.207.</li> <li>• Living arrangement - Intention to treat/randomised – control – lives alone n=159 (42.4%), lives with family/others n=216 (57.6%);</li> </ul>	<p>(20.3%), intervention n=177 (47.2%).</p> <p>Died - A lower proportion of participants in the intervention group had died compared to that in the control group; control n=72 (19.2%), intervention n=65 (17.3%).</p> <p>Residential care - A lower proportion of participants in the intervention group were residing in residential care compared to that in the control group; control n=48 (12.8%), intervention n=44 (11.7%).</p> <p>Other community service - A lower proportion of participants in the intervention group were in receipt of another community service compared to that in the control group; control n=16 (4.3%), intervention n=10 (2.7%).</p> <p>Declined/terminated - A higher proportion of participants in the</p>	

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	<p>intervention – lives alone n=192 (51.2%), lives with family/others n=183 (48.8%); p=0.016.</p> <ul style="list-style-type: none"> <li>Living arrangement – As treated – control – lives alone n=167 (42.3%), lives with family/others n=228 (57.7%); intervention – lives alone n=164 (52.9%), lives with family/others n=146 (47.1%); p=0.005.</li> </ul> <p><b>Baseline characteristics:</b></p> <ul style="list-style-type: none"> <li>Carer availability - Intention to treat/randomised – control – has a carer n=254 (67.7%), has no carer n=121 (32.3%); intervention – has a carer n=216 (57.6%), has no carer n=159 (42.4%); p=0.004.</li> <li>Carer availability – As treated – control – has a carer n=266 (67.3%), has no carer n=129 (32.7%); intervention – has a carer n=176 (56.8%), has no carer n=134 (43.2%); p=0.004.</li> </ul>	<p>intervention group had declined or terminated care compared to that in the control group; control n=4 (1.1%), intervention n=6 (1.6%).</p> <p>Admitted to hospital - A lower proportion of participants in the intervention group had been admitted to hospital compared to that in the control group; control n=3 (0.8%), intervention n=1 (0.3%).</p> <p>Moved out of area - A lower proportion of participants in the intervention group had moved out of the area compared to that in the control group; control n=5 (1.3%), intervention n=1 (0.3%).</p> <p>Hospice care - A higher proportion of participants in the intervention group had received hospice care compared to that in the control group; control n=1</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Carer status - Intention to treat/randomised – control – co-resident carer n=185 (72.8%), non-resident carer n=69 (27.2%); intervention – co-resident carer n=141 (65.6%), non-resident carer n=74 (34.4%); p=0.089.</li> <li>• Carer status – As treated – control – co-resident carer n=195 (73.3%), non-resident carer n=71 (26.7%); intervention – co-resident carer n=109 (62.3%), non-resident carer n=66 (37.7%); p=0.014.</li> <li>• Instrumental Activities of Daily Living total - Intention to treat/randomised – control – mean score 7.19 (3.61 SD); intervention – mean score 8.14 (3.23 SD); p&lt;0.001.</li> <li>• Instrumental Activities of Daily Living total – As treated – control – mean score 7.15 (3.67 SD); intervention – mean score 8.22 (3.11 SD); p&lt;0.001.</li> </ul>	<p>(0.3%), intervention n=4 (1.1%).</p> <p>Service outcomes at 3 months (as treated, control n=395 (100%), intervention n=310)</p> <p>Ongoing personal - A lower proportion of participants in the intervention group required ongoing personal care compared to that in the control group; control n=care 272 (68.9%), intervention n=66 (21.3%).</p> <p>No care required - A higher proportion of participants in the intervention group no longer required any care compared to that in the control group; control n=50 (12.6%), intervention n=163 (52.7%).</p> <p>Died - A lower proportion of participants in the intervention group had died compared to that in the control group; control n=26</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Activities of Daily Living total - Intention to treat/randomised – control – mean score 12.21 (3.18 SD); intervention – mean score 12.76 (2.75 SD); p=0.013.</li> <li>• Activities of Daily Living total – As treated – control – mean score 12.20 (3.13 SD); intervention – mean score 12.85 (2.72 SD); p=0.005.</li> </ul> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers – Randomised n=375 (recruited to subgroup n=150); completed baseline assessments n=395 (subgroup n=165); completed 3 month assessments n=395 (subgroup n=141); completed 12 month assessments n=395 (subgroup n=104).</li> <li>• Intervention numbers – Randomised n=375 (recruited to subgroup n=150); completed baseline</li> </ul>	<p>(6.6%), intervention n=13 (4.2%).</p> <p>Residential care - A lower proportion of participants in the intervention group were residing in residential care compared to that in the control group; control n=21 (5.3%), intervention n=14 (4.5%).</p> <p>Other community service - A higher proportion of participants in the intervention group were in receipt of another community service compared to that in the control group; control n=10 (2.5%), intervention n=10 (3.2%).</p> <p>Declined/terminated - A higher proportion of participants in the intervention group had declined or terminated care compared to that in the control group; control n=9 (2.3%), intervention n=12 (3.8%).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>assessments n=310 (subgroup n=129); completed 3 month assessments n=310 (subgroup n=111); completed 12 month assessments n=310 (subgroup n=88).</p> <ul style="list-style-type: none"> <li>• Sample size – Randomised N=750 (recruited to subgroup n=300); completed baseline assessments n=705 (subgroup n=294); completed 3 month assessments n=705 (subgroup n=252); completed 12 month assessments n=705 (subgroup n=192).</li> </ul> <p><b>Intervention:</b> Reablement.</p> <ul style="list-style-type: none"> <li>• Description - The intervention is described as a restorative home care programme.</li> <li>• Delivered by - The programme is delivered by the staff of Silver Chain, a care provider based in</li> </ul>	<p>Admitted to hospital - A higher proportion of participants in the intervention group had been admitted to hospital compared to that in the control group; control n=4 (1.0%), intervention n=23 (7.4%).</p> <p>Moved out of area - A lower proportion of participants in the intervention group had moved out of the area compared to that in the control group; control n=3 (0.8%), intervention n=0 (0.0%).</p> <p>Hospice care - A higher proportion of participants in the intervention group had received hospice care compared to that in the control group; control n=0 (0.0%), intervention n=9 (2.9%).</p> <p>Total - (100%).</p> <p>Service outcomes at 12 months (as treated, control</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>Western Australia. No details on the background or training level of staff are reported by the authors.</p> <ul style="list-style-type: none"> <li>Delivered to - The service is provided to older people who are eligible to receive Home and Community Care programme funded home care services. Individuals are eligible for the service if they require assistance in at least 1 task of daily living. The trials eligibility criteria restricted recruitment to individuals who had been referred for personal care (in order to reduce potential variance in dependency levels), were over the age of 65, and communicate in English. Individuals were excluded if they had a diagnosis of dementia or a progressive neurological disorder, or were in receipt of palliative care.</li> <li>Duration, frequency, intensity, etc. - The service is</li> </ul>	<p>n=395 (100%), intervention n=310)</p> <p>Ongoing personal care - A lower proportion of participants in the intervention group required ongoing personal care compared to that in the control group; control n=170 (43.0%), intervention n= 44 (14.2%).</p> <p>No care required - A higher proportion of participants in the intervention group no longer required any care compared to that in the control group; control n=71 (18.0%), intervention n=156 (49.3%).</p> <p>Died - A lower proportion of participants in the intervention group had died compared to that in the control group; control n=74 (18.7%), intervention n=56 (18.1%).</p> <p>Residential care - A lower proportion of participants in the intervention group were</p>	

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	<p>provided for up to 12 weeks or until the service user achieves their goals. NB No further details on frequency or intensity are provided.</p> <ul style="list-style-type: none"> <li>• Key components and objectives of intervention - The service is described as an early intervention that is designed to optimise functioning, to delay any decline in function, enable individuals to self-manage chronic disease, and promote healthy ageing. It is provided to individuals when they are initially referred for home care services, or to existing service users who request extra care. The key objective of the service is to reduce the need for ongoing support, and the intention is that the service is provided to participants before they have received any ongoing home care.</li> </ul>	<p>residing in residential care compared to that in the control group; control n=51 (12.9%), intervention n=35 (11.3%).</p> <p>Other community service - A lower proportion of participants in the intervention group were in receipt of another community service compared to that in the control group; control n=15 (3.8%), intervention n=10 (3.2%).</p> <p>Declined/terminated - A higher proportion of participants in the intervention group had declined or terminated care compared to that in the control group; control n=4 (1.0%), intervention n=4 (1.3%).</p> <p>Admitted to hospital - A lower proportion of participants in the intervention group had been admitted to hospital compared to that in the control group; control n=3</p>	

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	<ul style="list-style-type: none"> <li>Location/place of delivery - The service is provided in the participant's own home.</li> </ul> <p><b>Comparison intervention:</b> Care as usual. Participants randomised to the control group received standard Home and Community Care programme care provided by Silver Chain. This included a visit from a care co-ordinator to assess needs and complete a care plan. The authors report that the most common plan '...included 3 personal care visits a week to assist with bathing/showering and a fortnightly housecleaning visit that included heavy laundry' (p72).</p> <p><b>Outcomes measured:</b></p> <ul style="list-style-type: none"> <li>Service outcomes were measured by collating service data on need for ongoing personal care, no need for care, death, residential care placement,</li> </ul>	<p>(0.8%), intervention n=1 (0.3%). Moved out of area - A lower proportion of participants in the intervention group had moved out of the area compared to that in the control group; control n=5 (1.3%), intervention n=1 (0.3%). Hospice care - A higher proportion of participants in the intervention group had received hospice care compared to that in the control group; control n=2 (0.5%), intervention n=3 (1.0%).</p> <p>Logistic regression analysis – need for ongoing personal care at 3 months (intent to treat, adjusted for potential baseline confounders, n=592) Intervention vs. control: Participants in the intervention group were less likely to be in receipt of ongoing personal care than</p>	

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	<p>other community service, declined/terminated, admission to hospital, moved out of area, hospice care.</p> <ul style="list-style-type: none"> <li>• Activities of Daily Living and Instrumental Activities of Daily Living were both assessed using the Primary Assessment Form. This is a tool developed by care providers. The Activities of Daily Living scale appears to be based on the Modified Barthel Index (Colin et al. 1988) and the Instrumental Activities of Daily Living appears to be based on the Brody Scale (Lawton and Brody, 1969). The latter appears to have been modified to enable scoring to increase in relation to the assistance participants need for each task.</li> <li>• Mobility was measured using the Timed up and go test (Podsiadlo and Richardson 1991).</li> </ul>	<p>those in the control group (odds ratio = 0.18; 95% CI 0.13 to 0.26; <math>p &lt; 0.001</math>). This result was statistically significant.</p> <p>Carer availability: Participants with a carer were more likely to be in receipt of ongoing personal care than those without a carer (odds ratio = 1.68; 95% CI 0.95 to 1.09; <math>p = 0.008</math>). The significance of this result is unclear as the confidence interval and p value contradict each other.</p> <p>Higher Activities of Daily Living scale score at 12 months: Participants with higher levels of dependency at 12 months were more likely to be in receipt of ongoing personal care than those with lower levels of dependency at 12 months (odds ratio = 1.02; 95% CI 0.95 to 1.09; <math>p = 0.529</math>). This result was not statistically significant.</p>	

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	<ul style="list-style-type: none"> <li>• Fear of falling was measured using the Modified Falls Efficacy Scale (Hill et al. 1996).</li> <li>• Quality of life was measured using the Assessment of Quality of Life Scale (Hawthorne et al. 1997).</li> </ul> <p><b>Follow-up:</b> Follow-up assessments were conducted at 3 months and 12 months.</p> <p><b>Costs?</b> No. Costs information not included.</p>	<p>Logistic regression analysis – need for ongoing personal care at 12 months (intent to treat, adjusted for potential baseline confounders, n=473)</p> <p>Intervention vs. control:</p> <p>Participants in the intervention group were less likely to be in receipt of ongoing personal care than those in the control group (odds ratio = 0.22; 95% CI 0.15 to 0.32; p&lt;0.001). This result was statistically significant.</p> <p>Carer availability: Participants with a carer were more likely to be in receipt of ongoing personal care than those without a carer (odds ratio = 2.32; 95% CI 1.51 to 3.58; p&lt;0.001). This result was statistically significant.</p> <p>Higher Activities of Daily Living scale score at 12 months: Participants with higher levels of dependency at 12 months were more likely to be in receipt of</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>ongoing personal care than those with lower levels of dependency at 12 months (odds ratio = 1.08; 95% CI 1.00 to 1.17; p=0.048). This result approached significance.</p> <p>Logistic regression analysis – need for ongoing personal care at 3 months (as treated, adjusted for potential baseline confounders, n=558) Intervention vs. control: Participants in the intervention group were less likely to be in receipt of ongoing personal care than those in the control group (odds ratio = 0.10; 95% CI 0.07 to 0.15; p&lt;0.001). This result was statistically significant.</p> <p>Carer availability: Participants with a carer were more likely to be in receipt of ongoing personal care than those without a carer (odds ratio = 1.8; 95% CI 1.19 to 2.84;</p>	

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		<p>p=0.006). This result was statistically significant. Higher Activities of Daily Living scale score at 12 months: Participants with higher levels of dependency at 12 months were more likely to be in receipt of ongoing personal care than those with lower levels of dependency at 12 months (odds ratio = 1.04; 95% CI 0.96 to 1.12; p=0.297). This result was not statistically significant.</p> <p>Logistic regression analysis – need for ongoing personal care at 12 months (as treated, adjusted for potential baseline confounders, n=444) Intervention vs. control: Participants in the intervention group were less likely to be in receipt of ongoing personal care than those in the control group (odds ratio = 0.15; 95% CI 0.10 to 0.24; p&lt;0.001). This</p>	

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		<p>result was statistically significant.</p> <p>Carer availability: Participants with a carer were more likely to be in receipt of ongoing personal care than those without a carer (odds ratio = 2.55; 95% CI 1.60 to 4.07; <math>p &lt; 0.001</math>). ). This result was statistically significant.</p> <p>Higher Activities of Daily Living scale score at 12 months: Participants with higher levels of dependency at 12 months were more likely to be in receipt of ongoing personal care than those with lower levels of dependency at 12 months (odds ratio = 1.01; 95% CI 1.01 to 1.19; <math>p = 0.020</math>). This result was statistically significant.</p> <p>NB. The authors' report that other covariates used in logistic regression analysis included age, gender, scores on an Instrumental Activities</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>of Daily Living scale, and living arrangements. Data from these analyses are not reported.</p> <p>These analyses excluded participants who died or had a terminal illness, moved out of the area or in to residential care, and those who had missing data for any of the variables.</p> <p><b>Statistical data – service user related outcomes -</b>            Activities of Daily Living (assessed using the Primary Assessment Form. Only participants for whom data were available at baseline, 3 months and 12 months were included in the analysis, linear regression - adjustment made for potential confounders at baseline)            NB. Data not reported. The authors report narratively that both groups showed improvement on this measure between baseline and 3</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>months, and between 3 months and 12 months. It is stated that there were no between group differences on this measure.</p> <p>Instrumental Activities of Daily Living (assessed using the Primary Assessment Form. Only participants for whom data were available at baseline, 3 months and 12 months were included in the analysis, linear regression - adjustment made for potential confounders at baseline)  NB Data not reported in full.  The authors report narratively that both groups showed improvement on this measure between baseline and 3 months, and between 3 months and 12 months.  There was a significant difference between groups between baseline and 12 months with the control group showing an increase in dependency (p=0.016).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Mobility (measured using the Timed up and go test. Only participants for whom data were available at baseline, 3 months and 12 months were included in the analysis, linear regression - adjustment made for potential confounders at baseline) NB Data not reported. The authors report narratively that both groups showed improvement on this measure between baseline and 3 months, and between 3 months and 12 months. It is stated that there were no between group differences on this measure.</p> <p>Fear of falling (measured using the Modified Falls Efficacy Scale. Only participants for whom data were available at baseline, 3 months and 12 months were included in the analysis, linear regression - adjustment</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>made for potential confounders at baseline) NB Data not reported. The authors report narratively that both groups showed improvement on this measure between baseline and 3 months, and between 3 months and 12 months. It is stated that there were no between group differences on this measure.</p> <p>Quality of life (measured using the Assessment of Quality of Life Scale. Only participants for whom data were available at baseline, 3 months and 12 months were included in the analysis, linear regression - adjustment made for potential confounders at baseline) NB Data not reported. The authors report narratively that both groups showed improvement on this measure between baseline and 3 months, and between 3</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>months and 12 months. It is stated that there were no between group differences on this measure.</p> <p>Independence in everyday activities (% of subgroup clients with complete follow-up data [HIP: N = 100 and HACC: N = 98], baseline assessments were conducted over the telephone at referral to the service)</p> <p>NB Statistical analysis of between group differences is only reported for showering. It appears that some participants had received interventions before assessments using the Initial Primary Assessment Form had been conducted (originally intended as the 'baseline' assessment. The researchers therefore used the Home and Community Care programme Needs Identification telephone</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>assessment at referral as baseline data).</p> <p>Housework Baseline Home and Community Care programme Needs Identification – At baseline a lower proportion of the intervention group had independence in housework compared to that in the control group; intervention 0%; control 2%.</p> <p>Initial Primary Assessment Form – At initial visit by a research assistant a lower proportion of the intervention group had independence in housework compared to that in the control group; intervention 2%; control 7%.</p> <p>Three month follow-up assessment – At 3 month follow-up a higher proportion of the intervention group had independence in housework compared to that in the control group; intervention 9%; control 8%.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>1 year follow-up assessment  - At 1 year follow-up a higher proportion of the intervention group had independence in housework compared to that in the control group; intervention 11%; control 6%.</p> <p>Travel  Baseline Home and Community Care programme Needs Identification – At baseline a lower proportion of the intervention group had independence in travel compared to that in the control group; intervention 15%; control 21%.</p> <p>Initial Primary Assessment Form – At initial visit by a research assistant a lower proportion of the intervention group had independence in travel compared to that in the control group; intervention 14%; control 28%.</p> <p>Three month follow-up assessment – At 3 month follow-up a lower proportion</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>of the intervention group had independence in travel compared to that in the control group; intervention 21%; control 25%.            One year follow-up assessment – At 1 year follow-up the intervention group had lower levels of independence in travel compared to that in the control group; intervention 25%; control 31%.</p> <p>Shopping            Baseline Home and Community Care programme Needs Identification – At baseline a lower proportion of the intervention group had independence in shopping compared to that in the control group; intervention 5%; control 9%.</p> <p>Initial Primary Assessment Form – At initial visit by a research assistant a lower proportion of the intervention group had independence in</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>shopping compared to that in the control group; intervention 19%; control 21%.</p> <p>Three month follow-up assessment – At 3 month follow-up a higher proportion of the intervention group had independence in shopping compared to that in the control group; intervention 33%; control 26%.</p> <p>One year follow-up assessment – At 1 year follow-up a higher proportion of the intervention group had independence in shopping compared to that in the control group; intervention 34%; control 29%.</p> <p>Medication Baseline Home and Community Care programme Needs Identification – At baseline a higher proportion of the intervention group had independence in medication compared to that in the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>control group; intervention 68%; control 55%.</p> <p>Initial Primary Assessment Form – At initial visit by a research assistant a higher proportion of the intervention group had independence in medication compared to that in the control group; intervention 65%; control 54%.</p> <p>Three month follow-up assessment – At 3 month follow-up a higher proportion of the intervention group had independence in medication compared to that in the control group; intervention 69%; control 62%.</p> <p>One year follow-up assessment – At 1 year follow-up a higher proportion of the intervention group had independence in medication compared to that in the control group; intervention 64%; control 54%.</p> <p>Finances</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Baseline Home and Community Care programme Needs Identification – At baseline a higher proportion of the intervention group had independence in finances compared to that in the control group; intervention 58%; control 49%.</p> <p>Initial Primary Assessment Form – At initial visit by a research assistant a higher proportion of the intervention group had independence in finances compared to that in the control group; intervention 62%; control 57%.</p> <p>Three month follow-up assessment – At 3 month follow-up a higher proportion of the intervention group had independence in finances compared to that in the control group; intervention 69%; control 58%.</p> <p>One year follow-up assessment – At 1 year follow-up a higher proportion of the intervention group had</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>independence in finances compared to that in the control group; intervention 67%; control 49%.</p> <p>Phone Baseline Home and Community Care programme Needs Identification – At baseline a higher proportion of the intervention group had independence in using the phone compared to that in the control group; intervention 77%; control 67%.</p> <p>Initial Primary Assessment Form – At initial visit by a research assistant a higher proportion of the intervention group had independence in using the phone compared to that in the control group; intervention 86%; control 85%.</p> <p>Three month follow-up assessment – At 3 month follow-up a higher proportion of the intervention group had independence in using the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>phone compared to that in the control group; intervention 92%; control 89%.</p> <p>One year follow-up assessment – At 1 year follow-up a higher proportion of the intervention group had independence in using the phone compared to that in the control group; intervention 88%; control 84%.</p> <p>Prepare food Baseline Home and Community Care programme Needs Identification – At baseline a higher proportion of the intervention group had independence in preparing food compared to that in the control group; intervention 27%; control 20%.</p> <p>Initial Primary Assessment Form – At initial visit by a research assistant a higher proportion of the intervention group had independence in preparing food compared to that in the control group;</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>intervention 46%; control 36%.</p> <p>Three month follow-up assessment – At 3 month follow-up a higher proportion of the intervention group had independence in preparing food compared to that in the control group; intervention 60%; control 54%.</p> <p>One year follow-up assessment – At 1 year follow-up a higher proportion of the intervention group had independence in preparing food compared to that in the control group; intervention 55%; control 46%.</p> <p>Laundry Baseline Home and Community Care programme Needs Identification – At baseline a lower proportion of the intervention group had independence in laundry compared to that in the control group; intervention 17%; control 22%.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Initial Primary Assessment Form – At initial visit by a research assistant a higher proportion of the intervention group had independence in laundry compared to that in the control group; intervention 27%; control 20%.</p> <p>Three month follow-up assessment – At 3 month follow-up a higher proportion of the intervention group had independence in laundry compared to that in the control group; intervention 36%; control 29%.</p> <p>One year follow-up assessment – At 1 year follow-up a higher proportion of the intervention group had independence in laundry compared to that in the control group; intervention 37%; control 29%.</p> <p>Walking Baseline Home and Community Care programme Needs Identification – At</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>baseline a higher proportion of the intervention group had independence in walking compared to that in the control group; intervention 67%; control 63%.</p> <p>Initial Primary Assessment Form – At initial visit by a research assistant a higher proportion of the intervention group had independence in walking compared to that in the control group; intervention 97%; control 92%.</p> <p>Three month follow-up assessment – At 3 month follow-up a higher proportion of the intervention group had independence in walking compared to that in the control group; intervention 96%; control 94%.</p> <p>One year follow-up assessment – At 1 year follow-up a higher proportion of the intervention group had independence in walking compared to that in the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>control group; intervention 94%; control 89%.</p> <p>Showering Baseline Home and Community Care programme Needs Identification – At baseline a lower proportion of the intervention group had independence in showering compared to that in the control group; intervention 9%; control 18%.</p> <p>Initial Primary Assessment Form – At initial visit by a research assistant a significantly higher proportion of the intervention group were independent in showering compared to that in the control group; intervention 49%; control 30%; <math>\chi^2(1, n=192)=18.9, p&lt;0.001</math>.</p> <p>Three month follow-up assessment – At 3 month follow-up a significantly higher proportion of the intervention group were independent in showering</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>compared to that in the control group; intervention 69%; control 41%; <math>\chi^2(1, n=192)=25.9, p&lt;0.001</math>.            One year follow-up assessment – At 1 year follow-up a significantly higher proportion of the intervention group were independent in showering compared to that in the control group; intervention 67%; control 43%; <math>\chi^2(1, n=192)=16.65, p&lt;0.001</math>.</p> <p>Grooming            Baseline Home and Community Care programme Needs Identification – At baseline a higher proportion of the intervention group had independence in grooming compared to that in the control group; intervention 75%; control 63%.            Initial Primary Assessment Form – At initial visit by a research assistant a higher proportion of the intervention</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>group had independence in grooming compared to that in the control group; intervention 97%; control 85%.</p> <p>Three month follow-up assessment – At 3 month follow-up a higher proportion of the intervention group had independence in grooming compared to that in the control group; intervention 95%; control 92%.</p> <p>One year follow-up assessment – At 1 year follow-up a higher proportion of the intervention group had independence in grooming compared to that in the control group; intervention 96%; control 91%.</p> <p>Eating Baseline Home and Community Care programme Needs Identification – At baseline a higher proportion of the intervention group had independence in eating compared to that in the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>control group; intervention 87%; control 71%.</p> <p>Initial Primary Assessment Form – At initial visit by a research assistant a higher proportion of the intervention group had independence in eating compared to that in the control group; intervention 91%; control 85%.</p> <p>Three month follow-up assessment – At 3 month follow-up a higher proportion of the intervention group had independence in eating compared to that in the control group; intervention 94%; control 88%.</p> <p>One year follow-up assessment – At 1 year follow-up a higher proportion of the intervention group had independence in eating compared to that in the control group; intervention 91%; control 90%.</p> <p>Transfers</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Baseline Home and Community Care programme Needs Identification – At baseline a higher proportion of the intervention group had independence in transfers compared to that in the control group; intervention 81%; control 77%.</p> <p>Initial Primary Assessment Form – At initial visit by a research assistant a higher proportion of the intervention group had independence in transfers compared to that in the control group; intervention 98%; control 95%.</p> <p>Three month follow-up assessment – At 3 month follow-up a higher proportion of the intervention group had independence in transfers compared to that in the control group; intervention 97%; control 94%.</p> <p>One year follow-up assessment – At 1 year follow-up a higher proportion of the intervention group had</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>independence in transfers compared to that in the control group; intervention 97%; control 93%.</p> <p>Stairs Baseline Home and Community Care programme Needs Identification – At baseline a higher proportion of the intervention group had independence in using the stairs compared to that in the control group; intervention 14%; control 10%.</p> <p>Initial Primary Assessment Form – At initial visit by a research assistant a higher proportion of the intervention group had independence in using the stairs compared to that in the control group; intervention 39%; control 26%.</p> <p>Three month follow-up assessment – At 3 month follow-up a higher proportion of the intervention group had independence in using the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>stairs compared to that in the control group; intervention 44%; control 38%.            One year follow-up assessment – At 1 year follow-up a higher proportion of the intervention group had independence in using the stairs compared to that in the control group; intervention 46%; control 38%.</p> <p>Contenance            Baseline Home and Community Care programme Needs Identification – At baseline a higher proportion of the intervention group had independence in continence compared to that in the control group; intervention 76%; control 68%.            Initial Primary Assessment Form – At initial visit by a research assistant a lower proportion of the intervention group had independence in continence compared to that in the control group;</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>intervention 91%; control 92%.</p> <p>Three month follow-up assessment – At 3 month follow-up a higher proportion of the intervention group had independence in continence compared to that in the control group; intervention 93%; control 90%.</p> <p>One year follow-up assessment – At 1 year follow-up a higher proportion of the intervention group had independence in continence compared to that in the control group; intervention 95%; control 85%.</p> <p>Toileting Baseline Home and Community Care programme Needs Identification – At baseline a higher proportion of the intervention group had independence in toileting compared to that in the control group; intervention 89%; control 82%.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Initial Primary Assessment Form – At initial visit by a research assistant a lower proportion of the intervention group had independence in toileting compared to that in the control group; intervention 98%; control 95%.</p> <p>Three month follow-up assessment – At 3 month follow-up a lower proportion of the intervention group had independence in toileting compared to that in the control group; intervention 96%; control 97%.</p> <p>One year follow-up assessment – At 1 year follow-up a higher proportion of the intervention group had independence in toileting compared to that in the control group; intervention 94%; control 91%.</p> <p>Dressing Baseline Home and Community Care programme Needs Identification – At</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>baseline a higher proportion of the intervention group had independence in dressing compared to that in the control group; intervention 58%; control 51%.</p> <p>Initial Primary Assessment Form – At initial visit by a research assistant a lower proportion of the intervention group had independence in dressing compared to that in the control group; intervention 81%; control 70%.</p> <p>Three month follow-up assessment – At 3 month follow-up a lower proportion of the intervention group had independence in dressing compared to that in the control group; intervention 86%; control 73%.</p> <p>One year follow-up assessment – At 1 year follow-up a higher proportion of the intervention group had independence in dressing compared to that in the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		control group; intervention 78%; control 72%.	

**5. Lewin G and Vandermeulen S (2010) A non-randomised controlled trial of the Home Independence Program (HIP): An Australian restorative programme for older home-care clients. Health and Social Care in the Community 18: 91–9**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> To test the ‘... hypothesis that individuals referred for home care who participated in a restorative programme would have better personal (functional gain and improved well-being) and service (need for ongoing home care) outcomes than individuals who only received ‘usual’ home care’ (p92).</p> <p><b>Country:</b> Australia - metropolitan Perth.</p> <p><b>Methodology:</b> Comparison evaluation. Controlled trial.</p> <p><b>Source of funding:</b> Other - Western Australian Lotteries Commission.</p>	<p><b>Participants:</b> Service users and their families, partners and carers. The authors report that participants were elderly (over the age of 60) who had been referred for help with personal care or domestic tasks who were found to be eligible for both the Australian Home and Community Care programme and the Home Independence programme (the intervention). It is unclear what the eligibility criteria for these were and it appears that eligibility for the programmes has been conflated with eligibility for the trial however the authors go on to report that participants were ‘... experiencing difficulty in completing 1 or more tasks of</p>	<p><b>Statistical data - Service user related outcomes –</b> Activities of Daily Living (measured using the Primary Assessment Form, higher scores correspond to higher levels of dependency) - Between group differences in total mean score at 3 months: The intervention group had a lower total mean score on a measure of dependency in activities of daily living compared to the control group however this difference was not significant; intervention 9.3 (SD 0.9) vs. control 9.6 (SD 1.7). p value not reported, described as non-significant by authors.</p>	<p><b>Overall assessment of internal validity:</b> -</p> <p><b>Overall assessment of external validity:</b> ++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>daily living, did not require acute or post-acute care, did not have a diagnosis of dementia or other progressive neurological disorders and were able to communicate in English' (p92).</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Intervention mean age 79.6 years (SD 7.8); control mean age 79.8 years (SD 3.9).</li> <li>• Sex - Intervention n=77 (77%); control n=73 (73%).</li> <li>• Ethnicity - Not reported.</li> <li>• Religion/belief - Not reported.</li> <li>• Disability - Not reported.</li> <li>• Long term health condition - Not reported.</li> <li>• Socioeconomic position - Not reported.</li> </ul> <p><b>Baseline characteristics:</b></p> <ul style="list-style-type: none"> <li>• Lives alone - Intervention n=66 (66%); control n=77 (77%).</li> </ul>	<p>Between group differences in total mean score at 12 months: The intervention group had a lower total mean score on a measure of dependency in activities of daily living compared to the control group however this difference was not significant; intervention 9.3 (SD 0.8) vs. control 9.6 (SD 1.4). p value not reported, described as non-significant by authors.</p> <p>Between group differences in change in mean scores from baseline to 3 months: The intervention group showed significantly greater improvements between baseline and 3 months compared to the control group; <math>z=-3.71</math>, <math>p&lt;0.001</math>.</p> <p>Between group differences in change in mean scores from baseline to 12 months: The intervention group showed significantly greater improvements between baseline and 12 months</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Has carer - Intervention n=48 (48%); control n=34 (34%); p=0.044.</li> <li>• Activities of Daily Living total mean score - Intervention 9.9 (SD 1.4); control 9.6** (SD 1.4); p&lt;0.01.</li> <li>• Instrumental Activities of Daily Living total mean score - Intervention 16.4 (SD 4.1); control 14.8 (SD 4.5); p&lt;0.01.</li> <li>• Timed Up and Go mean time - Intervention 25.0 seconds (SD 14.1); control seconds 20.3 (SD 11.8); p&lt;0.01.</li> <li>• Modified Falls Efficacy Scale mean score - Intervention 7.4 (SD 1.5); control 7.7 (SD 1.6).</li> <li>• Philadelphia Geriatric Morale Scale mean score - Intervention 9.0 (SD 3.7); control 10.1 (SD 3.8); p&lt;0.01.</li> </ul> <p><b>Sample size:</b></p>	<p>compared to the control group; z=-2.90, p=0.004.</p> <p>Instrumental Activities of Daily Living (measured using the Primary Assessment Form, higher scores correspond to higher levels of dependency)</p> <p>Between group differences in total mean score at 3 months: The intervention group had a lower total mean score on a measure of dependency in instrumental activities of daily living compared to the control group however this difference was not significant; intervention 14.8 (SD 3.7) vs. control 14.9 (SD 4.1). p value not reported, described as non-significant by authors.</p> <p>Between group differences in total mean score at 12 months: The intervention group had a lower total mean score on a measure of dependency in instrumental activities of daily living</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Comparison - Consented and assessed at baseline n=100; completed 3 months follow-up assessments n=83; completed 12 months follow-up assessments n=73.</li> <li>• Intervention - Consented and assessed at baseline n=100; completed 3 months follow-up assessments n=82; completed 12 months follow-up assessments n=67.</li> <li>• Total sample size - Consented and assessed at baseline N=200; completed 3 months follow-up assessments n=165; completed 12 months follow-up assessments n=140.</li> </ul> <p><b>Intervention:</b> Reablement.</p> <ul style="list-style-type: none"> <li>• Description - The Home Independence Programme is described as an 'early intervention programme' that is designed to optimise function; delay or prevent further functional decline,</li> </ul>	<p>compared to the control group however this difference was not significant; intervention 14.0 (SD 2.8) vs. control 14.5 (SD 3.9). p value not reported, described as non-significant by authors.</p> <p>Between group differences in change in mean scores from baseline to 3 months: The intervention group showed significantly greater improvements between baseline and 3 months compared to the control group; <math>z=-4.20</math>, <math>p&lt;0.001</math>.</p> <p>Between group differences in change in mean scores from baseline to 12 months: The intervention group showed significantly greater improvements between baseline and 12 months compared to the control group; <math>z=-3.24</math>, <math>p=0.001</math>.</p> <p>Effect sizes for ADL and IADL, where lower score indicates more capacity to</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>enable self-management of chronic diseases, and promote healthy ageing.</p> <ul style="list-style-type: none"> <li>Delivered by - The programme is delivered by a home care provider called Silver Chain. Although the authors report that the service model includes an inter-disciplinary team comprised of a nurse, occupational therapist and physiotherapist they also note that only 1 of these practitioners works directly with the service user. No other details relating to the professionals delivering the intervention are provided.</li> <li>Delivered to - The intervention is specifically designed to be offered to individuals at the point of referral to home care services or to service users who are already in receipt of home care but have requested an increase in support.</li> </ul>	<p>live independently. ADL baseline: <math>d=0.2143</math>, 95% CI <math>-0.06374</math> to <math>0.4923</math>; ADL at 3 months: <math>d=-0.2202</math>, 95% CI <math>-0.5263</math> to <math>0.0859</math>; ADL at 12 months: <math>d=-0.2603</math>, 95% CI <math>-0.5933</math> to <math>0.0727</math>. IADL baseline: <math>d=0.3717</math>, 95% CI <math>0.0921</math> to <math>0.6513</math>; IADL at 3 months: <math>d=-0.0256</math>, 95% CI <math>-0.3308</math> to <math>0.2796</math>; IADL at 12 months: <math>d=-0.1463</math>, 95% CI <math>-0.4783</math> to <math>0.1858</math>.</p> <p>Mobility (measured using the Timed Up and Go test, lower levels of mobility are indicated by slower times) Between group differences in mean time (seconds) at 3 months: The intervention group had a quicker mean time on a measure of mobility compared to the control group however this difference was not significant; intervention <math>19.9</math> (SD <math>13.9</math>) vs. control <math>20.8</math> (SD <math>11.4</math>). <math>p</math></p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Duration, frequency, intensity, etc. - The service is usually provided for approximately 12 weeks, however this is dependent on success in meeting the service users goals and it should be noted that some participants may have received support for longer than 12 weeks (the number of which are not reported). No further details on frequency or intensity of the intervention are reported.</li> <li>• Key components and objectives of intervention - The main aim of the intervention is to minimise the need for ongoing care through a focus on functioning in the activities of daily living. This can be achieved by ‘... task analysis and redesign, work simplification and assistive technology ...’ (p93). The intervention includes ‘comprehensive</li> </ul>	<p>value not reported, described as non-significant by authors. Between group differences in mean time (seconds) at 12 months: The intervention group had a quicker mean time on a measure of mobility compared to the control group however this difference was not significant; intervention 18.9 (SD 6.8) vs. control 20.8 (SD 11.2). p value not reported, described as non-significant by authors. Between group differences in change in mean scores from baseline to 3 months: The intervention group showed significantly greater improvements between baseline and 3 months compared to the control group; <math>z=-5.98</math>, <math>p&lt;0.001</math>. Between group differences in change in mean scores from baseline to 12 months: Participants in the intervention group showed significantly greater</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>multidimensional assessment'; goal setting in collaboration with the service user; and education to enable self-management, healthy ageing, medication management, and prevention of accidents or illnesses. Other priorities that can be included are balance, strength and endurance work for mobility, falls prevention, continence management, nutrition management, and skin care. The authors also report that other key components of the intervention are 'minimised face-to-face contact' with telephone support and follow up (p93); a communication strategy that enables service users and their families to take part in decisions about care through promotion of a sense of autonomy; an understanding of the important role that home care services have as a form</p>	<p>improvements between baseline and 12 months compared to the control group; <math>z=-4.58</math>, <math>p&lt;0.001</math>.</p> <p>Fear of falling (measured using the Modified Falls Efficacy Scale, higher scores correspond to greater levels of confidence)</p> <p>Between group differences in mean scores at 3 months: The intervention group had a significantly higher mean score on a measure of fear of falling compared to the control group; intervention 8.4 (SD 1.1) vs. control 7.9 (SD 1.6); <math>p=0.034</math>.</p> <p>Between group differences in mean scores at 12 months: The intervention group had a higher mean score on a measure of fear of falling compared to the control group however this difference was not significant; intervention 8.3 (SD 1.3) vs. control 7.9 (SD 1.7). <math>p</math> value</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>of social support and assistance for service users to develop this type of support for themselves via other routes; and an awareness of local resources through use of a resource file. These components are collated in a Home Independence Programme user manual.</p> <ul style="list-style-type: none"> <li>• Content/session titles - N/A.</li> <li>• Location/place of delivery - The intervention is delivered in the service user's home.</li> </ul> <p><b>Comparison intervention:</b> Care as usual. Participants in the comparison group received standard Home and Community Care programme services. This included a telephone assessment to determine eligibility for the programme. If low level needs and assistance with domestic tasks only were identified services were scheduled at this point. For individuals with</p>	<p>not reported, described as non-significant by authors. Between group differences in change in mean scores from baseline to 3 months: The intervention group showed significantly greater improvements between baseline and 3 months compared to the control group; <math>z=5.99</math>, <math>p&lt;0.001</math>. Between group differences in change in mean scores from baseline to 12 months: The intervention group showed significantly greater improvements between baseline and 12 months compared to the control group; <math>z=3.62</math>, <math>p&lt;0.001</math>.</p> <p>Morale (measured using the Philadelphia Geriatric Morale Scale, higher scores correspond to better morale) Between group differences in mean scores at 3 months: The intervention group had a higher mean score on a</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>higher level needs an in person assessment by a care co-ordinator was arranged to devise a care plan and arrange services accordingly. The authors report that the ‘... most common care plan would include 3 personal care visits a week to assist with bathing/showering and a fortnightly home help visit to clean and do the heavy laundry’ (p94).</p> <p><b>Outcomes measured:</b> Service user related outcomes</p> <ul style="list-style-type: none"> <li>• Activities of Daily Living and Instrumental Activities of Daily Living were both assessed using the Primary Assessment Form. This is a tool developed by care providers. The Activities of Daily Living scale appears to be based on the Modified Barthel Index (Colin et al. 1988) and the Instrumental Activities of Daily Living appears to be based on the</li> </ul>	<p>measure of morale compared to the control group however this difference was not significant; intervention 10.4 (SD 3.6) vs. control 11.0 (SD 3.7). p value not reported, described as non-significant by authors.</p> <p>Between group differences in mean scores at 12 months: The intervention group had a higher mean score on a measure of morale compared to the control group however this difference was not significant; intervention 10.8 (SD 3.4) vs. control 10.9 (SD 3.6). p value not reported, described as non-significant by authors.</p> <p>Between group differences in change in mean scores from baseline to 3 months: The intervention group showed significantly greater improvements between baseline and 3 months compared to the control group; <math>z=2.41</math>, <math>p=0.016</math>.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>Brody Scale (Lawton and Brody, 1969). The latter appears to have been modified to enable scoring to increase in relation to the assistance participants need for each task. Higher scores correspond to higher levels of dependency.</p> <ul style="list-style-type: none"> <li>• Mobility was measured in seconds using the Timed Up and Go test (Podsiadlo and Richardson 1991).</li> <li>• Lower levels of mobility are indicated by slower times.</li> <li>• Fear of falling was measured using the Modified Falls Efficacy Scale (Hill et al. 1996). Higher scores correspond to greater levels of confidence.</li> <li>• Morale was measured using the Philadelphia Geriatric Morale Scale (Lawton 1975). Higher scores correspond to better morale.</li> </ul> <p>Service outcomes</p>	<p>Between group differences in change in mean scores from baseline to 12 months: The intervention group showed significantly greater improvements between baseline and 12 months compared to the control group; <math>z=2.04</math>, <math>p=0.041</math>.</p> <p>Linear regression estimates for group (intervention/control) and baseline scores for activities of daily living at 3 months follow-up</p> <p>Activities of Daily Living total - group: The amount of change in scores between baseline and 3 months follow-up was significantly influenced by group assignment with participants in the intervention group making greater improvements than those in the control group; estimate 0.43; 95% CI 0.12 to 0.74; <math>p=0.006</math>.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>Service outcomes were measured by collating provider level service data. Participants were classified as 'discharged – no longer required a service'; 'service requirement remained unchanged'; 'required a lower level of service'; 'required an increased level of service'; 'deceased'; 'entered residential care'; 'service cancelled or on hold' (participants who had been referred to palliative care services or were in hospital at 3 months) (p97).</p> <p><b>Follow-up:</b> Follow-up assessments took place at 3 and 12 months.</p> <p><b>Costs?</b> No. Costs or resource use information are not reported.</p>	<p>Activities of Daily Living total - baseline score: The amount of change in scores between baseline and 3 months follow-up was significantly influenced by baseline scores; estimate -0.28; 95% CI -0.40 to 0.16; p&lt;0.001.</p> <p>Linear regression estimates for group (intervention/control) and baseline scores for activities of daily living at 12 months follow up</p> <p>Activities of Daily Living total - group: The amount of change in scores between baseline and 12 months follow-up was significantly influenced by group assignment with participants in the intervention group making greater improvements than those in the control group; estimate 0.40; 95% CI 0.09 to 0.71; p=0.012.</p> <p>Activities of Daily Living total - baseline score: The amount</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>of change in scores between baseline and 12 months follow-up was significantly influenced by baseline scores; estimate -0.45; 95% CI -0.57 to -0.33; <math>p &lt; 0.001</math>.</p> <p>Linear regression estimates for group (intervention/control) and baseline scores for instrumental activities of daily living at 3 months follow up Instrumental Activities of Daily Living total - group: The amount of change in scores between baseline and 3 months follow-up was significantly influenced by group assignment with participants in the intervention group making greater improvements than those in the control group; estimate 1.35; 95% CI 0.58 to 2.13; <math>p = 0.001</math>.</p> <p>Instrumental Activities of Daily Living total - baseline score: The amount of change</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>in scores between baseline and 3 months follow-up was significantly influenced by baseline scores; estimate - 0.25; 95% CI -0.34 to -0.15; <math>p &lt; 0.001</math>.</p> <p>Linear regression estimates for group (intervention/control) and baseline scores for instrumental activities of daily living at 12 months follow up Instrumental Activities of Daily Living total - group: The amount of change in scores between baseline and 12 months follow-up was significantly influenced by group assignment with participants in the intervention group making greater improvements than those in the control group; estimate 1.32; 95% CI 0.36 to 2.27; <math>p = 0.008</math>.</p> <p>Instrumental Activities of Daily Living total - baseline score: The amount of change</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>in scores between baseline and 12 months follow-up was significantly influenced by baseline scores; estimate -0.47; 95% CI -0.59 to -0.35; <math>p &lt; 0.001</math>.</p> <p>Linear regression estimates for group (intervention/control) and baseline time for Timed Up and Go at 3 months follow up</p> <p>Timed Up and Go (minutes) - group: The amount of change in times between baseline and 3 months follow-up was significantly influenced by group assignment with participants in the intervention group making greater improvements than those in the control group; estimate 5.44; 95% CI 2.82 to 8.07; <math>p &lt; 0.001</math>.</p> <p>Timed Up and Go (minutes) - baseline time: The amount of change in scores between baseline and 3 months follow-up was significantly</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>influenced by baseline scores; estimate -0.19; 95% CI -0.29 to 0.09; <math>p &lt; 0.001</math>.</p> <p>Linear regression estimates for group (intervention/control) and baseline time for Timed Up and Go at 12 months follow up</p> <p>Timed Up and Go (minutes) - group: The amount of change in times between baseline and 12 months follow-up was significantly influenced by group assignment with participants in the intervention group making greater improvements than those in the control group; estimate 4.79; 95% CI 2.20 to 7.38; <math>p &lt; 0.001</math>.</p> <p>Timed Up and Go (minutes) - baseline time: The amount of change in scores between baseline and 12 months follow-up was significantly influenced by baseline</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>scores; estimate -0.39; 95% CI -0.52 to -0.26; p&lt;0.001.</p> <p>Linear regression estimates for group (intervention/control) and baseline scores for Modified Falls Efficacy Scale mean score at 3 months follow up</p> <p>Modified Falls Efficacy Scale mean score - group: The amount of change in scores between baseline and 3 months follow-up was significantly influenced by group assignment with participants in the intervention group making greater improvements than those in the control group; estimate -0.85; 95% CI -1.18 to -0.53; p&lt;0.001.</p> <p>Modified Falls Efficacy Scale mean score - baseline score: The amount of change in scores between baseline and 3 months follow-up was significantly influenced by baseline scores; estimate -</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>0.42; 95% CI -0.53 to -0.32; p&lt;0.001.</p> <p>Linear regression estimates for group (intervention/control) and baseline scores for Modified Falls Efficacy Scale mean score at 12 months follow up</p> <p>Modified Falls Efficacy Scale mean score - group: The amount of change in scores between baseline and 12 months follow-up was significantly influenced by group assignment with participants in the intervention group making greater improvements than those in the control group; estimate -0.68; 95% CI -1.14 to -0.21; p=0.005.</p> <p>Modified Falls Efficacy Scale mean score - baseline score: The amount of change in scores between baseline and 12 months follow-up was significantly influenced by baseline scores; estimate</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>-0.51; 95% CI -0.67 to -0.36; p&lt;0.001.</p> <p>Linear regression estimates for group (intervention/control) and baseline scores for Philadelphia Geriatric Morale Scale total score at 3 months follow up</p> <p>Philadelphia Geriatric Morale Scale total score - group: The amount of change in scores between baseline and 3 months follow-up was influenced by group assignment with participants in the intervention group making greater improvements than those in the control group; however this result was not significant; estimate -0.42; 95% CI -1.28 to 0.43; p=0.333.</p> <p>Philadelphia Geriatric Morale Scale total score - baseline score: The amount of change in scores between baseline and 3 months follow-up was</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>significantly influenced by baseline scores; estimate -0.29; 95% CI -0.42 to -0.18; <math>p &lt; 0.001</math>.</p> <p>Linear regression estimates for group (intervention/control) and baseline scores for Philadelphia Geriatric Morale Scale total score at 12 months follow up</p> <p>Philadelphia Geriatric Morale Scale total score - group: The amount of change in scores between baseline and 12 months follow-up was influenced by group assignment with participants in the intervention group making greater improvements than those in the control group; however, this result was not significant; estimate -0.59; 95% CI -1.61 to 0.43; <math>p = 0.254</math>.</p> <p>Philadelphia Geriatric Morale Scale total score - baseline score: The amount of change</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>in scores between baseline and 12 months follow-up was significantly influenced by baseline scores; estimate -0.45; 95% CI -0.60 to -0.29; p&lt;0.001.</p> <p><b>Statistical data - Service outcomes –</b>  Service outcomes at 3 months follow up (significance of results not reported)  ‘Discharged – no longer required a service’: At 3 months follow-up a larger number of participants in the intervention group were classified as no longer requiring care compared to that in the control group; intervention n=63 vs. control n=11.  ‘Service requirement remained unchanged’: At 3 months follow-up a smaller number of participants in the intervention group were classified as having</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>unchanged service requirements compared to that in the control group; intervention n=18 vs. control n=67.</p> <p>'Required a lower level of service': At 3 months follow-up a larger number of participants in the intervention group were classified as requiring a lower level of service compared to that in the control group; intervention n=3 vs. control n=0.</p> <p>'Required an increased level of service': At 3 months follow-up a smaller number of participants in the intervention group were classified as requiring a higher level of service compared to that in the control group; intervention n=0 vs. control n=13.</p> <p>Deceased: At 3 months follow-up an equal number of participants in each group</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>had died; intervention n=4 vs. control n=4.</p> <p>'Entered residential care': At 3 months follow-up a smaller number of participants in the intervention group had entered residential care compared to that in the control group; intervention n=1 vs. control n=2.</p> <p>'Service cancelled or on hold': At 3 months follow-up a larger number of participants in the intervention group had had their service cancelled or placed on hold compared to that in the control group; intervention n=9 vs. control n=3.</p> <p>Service outcomes at 12 months follow up (significance of results not reported)</p> <p>'Discharged – no longer required a service': At 12 months follow-up a larger number of participants in the intervention group were</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>classified as no longer requiring care compared to that in the control group; intervention n=57 vs. control n=19.</p> <p>'Service requirement remained unchanged: At 12 months follow-up a smaller number of participants in the intervention group were classified as having unchanged service requirements compared to that in the control group; intervention n=19 vs. control n=58.</p> <p>'Required a lower level of service': At 12 months follow-up a larger number of participants in the intervention group were classified as requiring a lower level of service compared to that in the control group; intervention n=8 vs. control n=7.</p> <p>'Required an increased level of service': At 12 months follow-up a larger number of</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>participants in the intervention group were classified as requiring a higher level of service compared to that in the control group; intervention n=3 vs. control n=1.</p> <p>Deceased: At 12 months follow-up an equal number of participants in each group had died; intervention n=11 vs. control n=11.</p> <p>'Entered residential care': At 12 months follow-up a smaller number of participants in the intervention group had entered residential care compared to that in the control group; intervention n=2 vs. control n=4.</p> <p>'Service cancelled or on hold': At 12 months follow-up there were no participants in either group who had had their service cancelled or placed on hold; intervention n=0 vs. control n=0.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Service outcome (continuing to receive service vs. no longer requiring a service) at 3 months (logistic regression, n=165)</p> <p>Demographic: Not a significant predictor. Data not provided, reported narratively by the authors.</p> <p>Outcomes (scores at different follow-ups): Not a significant predictor. Data not provided, reported narratively by the authors.</p> <p>Group: (intervention/control): At 3 months, participants in the intervention group were 0.07 times less likely than those in the control group to still require services. This result was statistically significant; intervention n=63 (63%) vs. control n=11 (11%); odds ratio = 0.07 (95% CI 0.03 to 0.15); p&lt;0.001.</p> <p>NB. Variables were adjusted for age; carer availability; gender; living arrangements;</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>and scores on Activities of Daily Living, Instrumental Activities of Daily Living, Timed Up and Go, Modified Falls Efficacy and Philadelphia Geriatric Morale scale.</p> <p>Service outcome (continuing to receive service vs. no longer requiring a service) at 12 months (logistic regression, n=140) Demographic: Not a significant predictor. Data not provided, reported narratively by the authors. Outcomes (scores at different follow-ups): Not a significant predictor. Data not provided, reported narratively by the authors. Group: (intervention/control): At 12 months, participants in the intervention group were 0.14 times less likely than those in the control group to still require services. This result was statistically</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>significant; intervention n=57 (57%) vs. control n=19 (19%); odds ratio = 0.14 (95% CI 0.07 to 0.29); p&lt;0.001.</p> <p>NB. Variables were adjusted for age; carer availability; gender; living arrangements; and scores on Activities of Daily Living, Instrumental Activities of Daily Living, Timed Up and Go, Modified Falls Efficacy and Philadelphia Geriatric Morale scale.</p>	

**6. Tinetti ME, Charpentier P, Gottschalk M et al. (2012) Effect of a Restorative Model of Posthospital Home Care on Hospital Readmissions. Journal of the American Geriatrics Society 60: 1521-6**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> To compare readmissions of Medicare recipients of usual home care and a matched group of recipients of a restorative model of home care.</p>	<p><b>Participants:</b> Service users and their families, partners and carers - Individuals using care from a large home care agency after hospitalisation.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>Age - Restorative model</li> </ul>	<p><b>Statistical data – service outcomes -</b></p> <p>Number of readmissions: Matched pairs (n=341 pairs) restorative care 45/341 (13.2%) vs. usual care 60/341 (17.6%); p=0.10; 95%</p>	<p><b>Overall assessment of internal validity:</b></p> <p>+</p> <p><b>Overall assessment of external validity:</b></p> <p>++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Methodology:</b> Comparison evaluation. Quasi-experimental evaluation.</p> <p><b>Country:</b> USA.</p> <p><b>Source of funding:</b> Other - Private foundation.</p>	<p>mean (all) 77.4±6.7; mean (matched pairs) 77.4±6.5. Usual care mean (all) 77.0±6.7; mean (matched pairs) 77.4±6.5.</p> <ul style="list-style-type: none"> <li>• Sex - Restorative model male (all) 191 (47%); male (matched pairs) 159 (47%). Usual care male 168 (47%); male (matched pairs) 159 (47%).</li> <li>• Ethnicity - Restorative model - non-white (all) 15 (4%); non-white (matched pairs) 12 (4%). Usual care non-white 14 (4%); non-white (matched pairs) 12 (4%).</li> <li>• Disability - Restorative model - dependence in &gt;1 self-care activity of daily living (all) 211 (51%); dependence in &gt;1 self-care activity of daily living (matched pairs) 161 (47%). Usual care dependence in &gt;1 self-care activity of daily living (all) 171 (48%); dependence in &gt;1 self-care activity of daily living</li> </ul>	<p>CI 0.68 (0.43 to 1.08); odds ratio = 0.68.</p> <p>Number of readmissions: Un-matched analysis (n=770) restorative care 53/410 (12.9%) vs. usual care 62/360 (17.2%); p=0.09; 95% CI 0.71 (0.47 to 1.06); odds ratio = 0.71.</p> <p>Mean length of stay in intervention or control: Restorative care 20.3±14.8 (interquartile range 11-24) vs. usual care 29.1±31.7 (interquartile range 13-34); p&lt;0.001.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>(matched pairs) 161 (47%).</p> <ul style="list-style-type: none"> <li>Long term health condition - Restorative model - Cardiac - All 288 (70%); matched pairs 233 (68%). Respiratory - all 90 (22%); matched pairs 82 (24%). Diabetes mellitus - all 89 (22%); matched pairs 73 (22%). Neurological - all 29 (7%); matched pairs 24 (7%). Two or more of these categories of chronic conditions - 227 (55%) matched pairs 189 (55%). Usual care – Cardiac - all 247 (69%); matched pairs 236 (69%). Respiratory - all 63 (18%); matched pairs 61 (18%). Diabetes mellitus - all 90 (26%); matched pairs 84 (26%). Neurological - all 25 (7%); matched pairs 23 (7%). Two or more of these categories of chronic conditions - 208 (58%); matched Pairs 200 (59%).</li> </ul> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>Description - A restorative</li> </ul>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>model of home care based on principles from geriatric medicine, nursing, rehabilitation, goal attainment, chronic care management and behavioural change theory. The aim is to re-orientate home care from disease treatment and ‘taking care of’ patients to working together to maximise function.</p> <ul style="list-style-type: none"> <li>• Delivered by - Nursing, physiotherapy, occupational therapy &amp; home health aide staff.</li> <li>• Delivered to - People receiving home care from a large home care agency in Connecticut.</li> <li>• Key components and objectives of intervention - Important elements - (see table 1, p1522) - development and implementation of a unified plan of care based on goal attainment; establishment of goals based on input from</li> </ul>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>the individual, family, and home care staff; agreement on the process for reaching these goals; reorganization of the home care staff from individual care providers into an integrated, interdisciplinary team with shared goals; reorientation of the focus of the home care team from primarily treating diseases and 'taking care of' patients toward maximising self-care function; clarification of roles and responsibility of providers; standard assessment of patients; self-care progress report; track progress toward reaching goals; treatment plans targeting physical impairments and tasks of daily living; behavioural changes; environmental adjustments and adaptive equipment; counselling and support; training of patient, family, and caregivers; and</p>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>medication adjustments.</p> <p><b>Outcomes measured:</b> Service outcomes - Frequency of hospital readmissions and mean length of home care episodes.</p> <p><b>Costs?</b> No cost or economic data are reported but the authors suggest that the findings show that restorative care is cost effective, 'The reduction in hospital readmissions and ED visits, coupled with shorter episodes of home care, support the cost-effectiveness of the restorative model' (p1524). They also calculate that the 15 fewer readmissions in the restorative compared with usual care group translates to \$108,000 in 2005 Medicare dollars saved in the study sample.</p>		

7. Tuntland H, Aaslund MK, Espehaug B et al. (2015) Reablement in community-dwelling older adults: A randomised controlled trial. *BMC Geriatrics* 15: 145

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The authors aimed to ‘... evaluate whether reablement is more effective with regard to self-perceived activity performance and satisfaction with performance, physical functioning, and health-related quality of life compared with usual care’ (p2).</p> <p><b>Country:</b> Norway. The study is reported to have been conducted in a rural municipality with a population of around 14,000.</p> <p><b>Methodology:</b> Randomised controlled trial.</p> <p><b>Source of funding:</b></p> <ul style="list-style-type: none"> <li>• Government – Regional Research Funds Western Norway, grant number 229759.</li> <li>• Other - Norwegian Association of Occupational Therapists.</li> </ul>	<p><b>Participants:</b> Service users and their families, partners and carers - Individuals who had applied or been referred for home care due to self-reported limitations in activity were assessed for eligibility. The trial included both individuals who had been admitted to hospital as a result of acute illness as well as those who had experienced a gradual decline in function without admission.</p> <p>To be eligible, individuals had to be over the age of 18, living in their own home in the municipality, able to understand Norwegian and to have experienced functional decline in at least 1 daily activity.</p> <p>Individuals were excluded if they needed admission to a rehabilitation unit or nursing</p>	<p><b>Statistical data - service user related outcomes –</b> NB. Some effect sizes were not presented by the authors. Those that were not were calculated by the review team.</p> <p>Usage of home-based services and distribution of health-care professions during the first 3 months: effect sizes</p> <p>Mean home visits per person: d=0.0959; 95% CI -0.4516 to 0.6435.</p> <p>Mean home visits per person per week: d=0.1677; 95% CI -0.3805 to 0.7159.</p> <p>Mean hours home-based service per person: d=0.1506; 95% CI -0.3974 to 0.6986.</p> <p>Mean hours home-based service per person per week: d=0.1591; 95% CI -0.389 to 0.7072.</p>	<p><b>Overall assessment of internal validity:</b> ++</p> <p><b>Overall assessment of external validity:</b> ++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>home, if they had a terminal illness, or if they were assessed (by health care providers) as having a moderate or severe cognitive impairment.</p> <p>The authors note that baseline scores on outcome measures such as the Timed Up and Go test suggest that the sample was relatively frail with low physical function in comparison to the wider population of 70-79 year olds living in the community.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age – Intervention mean 79.9 years (10.4 SD); control mean 78.1 years (9.8 SD); p=0.49.</li> <li>• Sex – Intervention n=22 female (71.0%); control n=19 female (63.3%); p=0.53.</li> <li>• Ethnicity – Not reported.</li> <li>• Religion/belief – Not reported.</li> </ul>	<p>Activity performance (self-reported, measured using the Canadian Occupational Performance Measure, sum score, 1–10, 10=best)</p> <p>Three months: There was a significant mean difference in scores of 1.5 points on a self-reported measure of activity performance in favour of the intervention group at 3 months, with large effect sizes being observed; adjusted effect size d=0.8; treatment effect mean difference = 1.5 (95% CI 0.3 to 2.8); p=0.02.</p> <p>Nine months: There was a significant mean difference in scores of 1.4 points on a self-reported measure of activity performance in favour of the intervention group at 9 months, with medium to large effect sizes being observed; adjusted effect size d=0.7; treatment effect mean difference = 1.4 (95% CI 0.2 to 2.7); p=0.03.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Disability – Not reported.</li> <li>• Long term health condition – Not reported.</li> <li>• Sexual orientation – Not reported.</li> <li>• Socioeconomic position –</li> <li>• Married/cohabitating – intervention n=10 (32.3%); control n=4 (13.3%); p=0.08.</li> <li>• Education - university/university college - intervention n=27 (87.1%); control n=24 (80.0%); p=0.51.</li> <li>• Retired - intervention n=28 (90.3%); control n=26 (86.7%); p=0.65.</li> </ul> <p><b>Baseline characteristics:</b></p> <ul style="list-style-type: none"> <li>• Motivation for rehabilitation (1–10, 10=best) – intervention mean 7.5 (2.3 SD); control mean 7.7 (2.1 SD); p=0.70.</li> <li>• Total number of prescribed medications – intervention mean 6.1 (2.8 SD), range 13; control mean 6.7 (3.1</li> </ul>	<p>Whole trial period of 9 months: There was a significant overall treatment effect of 1.5 points on a self-reported measure of activity performance in favour of the intervention group over the whole 9 month study period; overall treatment effect mean difference = 1.5 (95% CI 0.4 to 2.6); p=0.01.</p> <p>Activity satisfaction (self-reported, measured using the Canadian Occupational Performance Measure, sum score, 1–10, 10=best)  Three months: There was a mean difference in scores of 1.0 points on a self-reported measure of activity satisfaction in favour of the intervention group at 3 months, however this result was not statistically significant. Medium to large effect sizes were observed; adjusted effect size d=0.7; treatment effect mean</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>SD), range 11; p=0.46.</p> <ul style="list-style-type: none"> <li>• Self-reported number of medical conditions – intervention mean 3.0 (1.7 SD), range 8; control mean 2.9 (1.1 SD), range 4; p=0.79.</li> <li>• Category of main medical condition – p=0.42.</li> <li>• Cardiovascular condition – intervention n=5 (16.1%); control n=2 (6.7%).</li> <li>• Neurological condition included strokes – intervention n=8 (25.8%); control n=8 (26.7%).</li> <li>• Orthopaedic condition – intervention n=10 (32.3%); control n=12 (40.0%).</li> <li>• Lung condition – intervention n=4 (12.9%); control n=1 (3.3%).</li> <li>• Other/unspecified condition – intervention n=4 (12.9%); control n=7 (23.3%).</li> <li>• Activity performance (Canadian Occupational Performance Measure, sum</li> </ul>	<p>difference = 1.0 (95% CI -0.3 to 2.2); p=0.13.</p> <p>Nine months: There was a significant mean difference in scores of 1.4 points on a self-reported measure of activity satisfaction in favour of the intervention group at 9 months, with large effect sizes being observed; adjusted effect size d=0.9; treatment effect mean difference 1.4 (95% CI 0.1 to 2.7); p=0.03.</p> <p>Whole trial period of 9 months: There was a significant overall treatment effect of 1.2 points on a self-reported measure of activity satisfaction in favour of the intervention group over the whole 9 month study period; treatment effect mean difference 1.2 (95% CI 0.1 to 2.3); p=0.04.</p> <p>Functional mobility (measured in seconds using the Timed Up and Go)</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>score, 1–10, 10=best) – intervention mean 2.6 (1.5 SD); control mean 2.8 (1.4 SD); p=0.70.</p> <ul style="list-style-type: none"> <li>• Activity satisfaction (Canadian Occupational Performance Measure, sum score, 1–10, 10=best) – intervention mean 2.6 (1.6 SD); control mean 3.3 (1.9 SD); p=0.12.</li> <li>• Mobility and balance (Timed Up and Go, seconds, n=56) – intervention mean 24.6 (11.9 SD); control mean 23.3 (17.3 SD); p=0.73.</li> <li>• Grip strength (Jamar dynamometer, men right hand, kg, n = 19) – intervention mean 24.4 (14.1 SD); control mean 28.8 (9.6 SD); p=0.43.</li> <li>• Grip strength (Jamar dynamometer, men left hand, kg, n=17) – intervention mean 27.3 (13.4 SD); control mean 25.8 (9.0 SD); p=0.79.</li> </ul>	<p>Three months: There was a mean difference in times of –0.4 seconds on a measure of functional ability in favour of the intervention group at 3 months. This result was not statistically significant and effect sizes were small; adjusted effect size d=0.1; treatment effect mean difference –0.4 (95% CI –4.3 to 3.5); p=0.82.</p> <p>Nine months: There was a mean difference in times of 0.3 seconds on a measure of functional ability in favour of the control group at 9 months. This result was not statistically significant and effect sizes were small; adjusted effect size d=0.1; treatment effect mean difference 0.3 (95% CI –3.7 to 4.3); p=0.88.</p> <p>Whole trial period of 9 months: There was an overall treatment effect –0.1 seconds on a measure of functional ability in favour of the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Grip strength (Jamar dynamometer, women, right hand, kg, n=39) – intervention mean 17.7 (5.7 SD); control mean 15.8 (6.6 SD); p=0.34.</li> <li>• Grip strength (Jamar dynamometer, women, left hand, kg, n=41) – intervention mean 17.1 (6.7 SD); control mean 14.4 (6.1 SD); p=0.18.</li> <li>• Physical fitness (COOP/Wonka, scale 1–5, 1=best) – intervention mean 4.4 (0.6 SD); control mean 4.2 (0.7 SD); p=0.29.</li> <li>• Feelings (COOP/Wonka, scale 1–5, 1=best) – intervention mean 2.4 (1.5 SD); control mean 2.3 (0.9 SD); p=0.71.</li> <li>• Daily activities (COOP/Wonka, scale 1–5, 1=best) – intervention mean 3.5 (1.1 SD); control mean 3.2 (0.8 SD); p=0.16.</li> <li>• Social activities</li> </ul>	<p>intervention group over the whole 9 month study period; treatment effect mean difference –0.1 (95% CI –3.8 to 3.5); p=0.96. This result was not statistically significant.</p> <p>Grip strength – right hand (measured in kilograms using the Jamar dynamometer)  Three months: There was a mean difference in scores of -0.3 kg on a measure of right handed grip strength in favour of the control group at 3 months. This result was not statistically significant and effect sizes were small; adjusted effect size d=0.1; treatment effect mean difference –0.3 (95% CI 2.5 to 2.0); p=0.81.  Nine months: There was a mean difference in scores of -0.3 kg on a measure of right handed grip strength in favour of the control group at 9 months. This result was not</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>(COOP/Wonka, scale 1–5, 1=best) – intervention mean 2.4 (1.4 SD); control mean 2.9 (1.3 SD); p=0.13.</p> <ul style="list-style-type: none"> <li>• Change in health (COOP/Wonka, scale 1–5, 1=best) – intervention mean 2.4 (1.0 SD); control mean 2.1 (0.9 SD); p=0.34.</li> <li>• Overall health (COOP/Wonka, scale 1–5, 1=best) – intervention mean 3.0 (0.9 SD); control mean 2.9 (0.8 SD); p=0.46.</li> </ul> <p><b>Activities prioritised by participants using Canadian Occupational Performance Measure:</b></p> <ul style="list-style-type: none"> <li>• Self-care/personal care – n=36 (including - dressing n=5; eating with cutlery n=3; going to the toilet n=5; personal hygiene n=9).</li> <li>• Self-care/mobility – n=89 (including - climbing stairs n=13; transferring from bed or chair n=14; walking indoors with/without walking</li> </ul>	<p>statistically significant and effect sizes were small; adjusted effect size d=0.1; treatment effect mean difference –0.6 (95% CI –2.9 to 1.7); p=0.59.</p> <p>Whole trial period of 9 months: There was an overall treatment effect of –0.4 kg on a measure of right handed grip strength in favour of the control group over the whole 9 month study period. This result was not statistically significant; treatment effect mean difference –0.4 (95% CI –2.4 to 1.5); p=0.66.</p> <p>Grip strength – left hand (measured in kilograms using the Jamar dynamometer) - Three months: There was a mean difference in scores of -0.1 kg on a measure of left handed grip strength in favour of the control group at 3 months. This result was not statistically significant and effect sizes were small;</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>aids n=24; walking outdoors with/without walking aids n=21; walking outdoors towards defined target - n=17).</p> <ul style="list-style-type: none"> <li>• Productivity/community management - n=19.</li> <li>• Productivity/paid or unpaid work - n=2.</li> <li>• Productivity/household arrangement – n=44 (including - carry items n=7; clean or vacuum house n=20; prepare food n=10; wash clothes n=7).</li> <li>• Productivity/play/school – n=0.</li> <li>• Leisure/quiet recreation – n=10.</li> <li>• Leisure/active recreation – n=17.</li> <li>• Leisure/socialisation – n=11.</li> </ul> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Comparison numbers – Randomised n=30; completed 3 month follow-up assessment n=26;</li> </ul>	<p>adjusted effect size <math>d=-0.1</math>; treatment effect mean difference <math>-0.1</math> (95 % CI <math>-3.1</math> to <math>2.8</math>); <math>p=0.92</math>.</p> <p>Nine months: There was a mean difference in scores of <math>-2.2</math> kg on a measure of left handed grip strength in favour of the control group at 3 months. This result was not statistically significant and effect sizes were small; adjusted effect size <math>d=-0.3</math>; treatment effect mean difference <math>-2.2</math> (95% CI <math>-5.2</math> to <math>0.9</math>); <math>p=0.16</math>.</p> <p>Whole trial period of 9 months: There was an overall treatment effect of <math>-1.1</math> kg on a measure of left handed grip strength in favour of the control group over the whole 9 month study period. This result was not statistically significant; treatment effect mean difference <math>-1.1</math> (95 % CI <math>-3.5</math> to <math>1.3</math>); <math>p=0.36</math>.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>completed 9 month follow-up assessment n=26.</p> <ul style="list-style-type: none"> <li>• Intervention numbers – Randomised n=31; completed 3 month follow-up assessment n=28; completed 9 month follow-up assessment n=25.</li> <li>• Sample size - Randomised N=61; completed 3 month follow-up assessment n=54; completed 9 month follow-up assessment n=51.</li> </ul> <p><b>Intervention:</b> Reablement.</p> <ul style="list-style-type: none"> <li>• Description - The intervention is described as multicomponent home based rehabilitation.</li> <li>• Delivered by - An occupational therapist and a physical therapist worked with participants to identify issues that hindered their ability to perform everyday tasks and these were translated into a rehabilitation plan that underpinned the work that</li> </ul>	<p>Health related quality of life – physical fitness (self-reported, measured using COOP/Wonka, scale 1–5, 1=best</p> <p>Three months: There was no difference in mean scores on a self-reported measure of physical fitness at 3 months. Small effect sizes were observed. The result was not statistically significant; adjusted effect size <math>d=-0.2</math>; treatment effect mean difference 0.0 (95% CI -0.4 to 0.5); <math>p=0.94</math>.</p> <p>Nine months: There was a mean difference in scores of -0.4 points on a self-reported measure of physical fitness in favour of the intervention group at 9 months, however this result was not statistically significant. Medium effect sizes were observed; adjusted effect size <math>d=-0.6</math>; treatment effect mean difference -0.4 (95% CI -0.9 to 0.1); <math>p=0.09</math>.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>home care personnel carried out with the service user (supervised by the occupational and physical therapists). The authors report that although some of the home care staff had not previously been trained in reablement, all of those involved received training before the intervention was rolled out. This focused on the 'ideology' of self-management. Home care staff and therapists held weekly informal meetings to '... ensure good communication and follow-up of individual participants' (p3).</p> <ul style="list-style-type: none"> <li>Delivered to - Individuals who had applied or been referred for home care due to self-reported limitations in at least 1 activity (included both individuals who had been admitted to hospital due to an acute episode and those who had experienced</li> </ul>	<p>Whole trial period of 9 months: There was an overall treatment effect of -0.2 points on a self-reported measure of physical fitness in favour of the intervention group over the whole 9 month study period, however this result was not statistically significant; treatment effect mean difference -0.2 (95% CI -0.6 to 0.2); p=0.34.</p> <p>Health related quality of life – feelings (self-reported, measured using COOP/Wonka, scale 1–5, 1=best)</p> <p>Three months: There was no difference in mean scores on a self-reported measure of feelings at 3 months. Small effect sizes were observed. The result was not statistically significant; adjusted effect size d = 0.0; treatment effect mean difference 0.0 (95% CI -0.5 to 0.6); p=0.89.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>general functional decline without experiencing hospital admission.) Although the service was available to all residents in the municipality, the sample in this study tended to be older females who were living alone. The authors note that baseline scores on outcome measures such as the Timed Up and Go test suggest that the sample was relatively frail.</p> <ul style="list-style-type: none"> <li>• Duration, frequency, intensity, etc. - The maximum period for which the service could be provided was 3 months and the authors report that the average duration was ten weeks. No further details on frequency or intensity of sessions are reported.</li> <li>• Key components and objectives of intervention - The intervention aims to enable participants to perform daily activities</li> </ul>	<p>Nine months: There was no difference in mean scores on a self-reported measure of feelings at 9 months. Small effect sizes were observed. The result was not statistically significant; adjusted effect size <math>d=-0.1</math>; treatment effect mean difference 0.0 (95% CI -0.6 to 0.6); <math>p=1.00</math>.</p> <p>Whole trial period of 9 months: There was no evidence of an overall treatment on a self-reported measure of feelings over the whole 9 month study period. This was not statistically significant; treatment effect mean difference 0.0 (95% CI -0.5 to 0.5); <math>p=0.90</math>.</p> <p>Health related quality of life – daily activities (self-reported, measured using COOP/Wonka, scale 1–5, 1=best)</p> <p>Three months: There was a mean difference in scores of -</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>themselves rather than relying on others. The Canadian Occupational Performance Measure is used to identify issues that restricted the everyday activities of participants. These were then translated into a rehabilitation plan which home care personnel used in their work with participants. The authors report that the ‘... focus was on stimulating the participants to perform the daily activities themselves, rather than letting others do it for them. Among the individual features were training in daily activities, adaptations to the environment or the activity, and exercise programs’ (p3). Participants also received booklets illustrating simple exercises.</p> <ul style="list-style-type: none"> <li>• Location/place of delivery - The service is provided in the participant’s own home.</li> </ul>	<p>0.4 points on a self-reported measure of daily activity in favour of the intervention group at 3 months, however this result was not statistically significant. Medium effect sizes were observed; adjusted effect size <math>d=-0.6</math>; treatment effect mean difference <math>-0.4</math> (95% CI <math>-0.9</math> to <math>0.2</math>); <math>p=0.21</math>.</p> <p>Nine months: There was a mean difference in scores of <math>-0.4</math> points on a self-reported measure of daily activity in favour of the intervention group at 9 months, however this result was not statistically significant. Medium effect sizes were observed; adjusted effect size <math>d=-0.6</math>; treatment effect mean difference <math>-0.4</math> (95% CI <math>-0.3</math> to <math>0.5</math>); <math>p=0.22</math>.</p> <p>Whole trial period of 9 months: There was an overall treatment effect of <math>-0.4</math> on a self-reported measure of daily activity in favour of the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p><b>Comparison intervention:</b> Care as usual. The control intervention was not time-limited and was provided for more than 3 months where necessary. The authors report that usual care most commonly comprised of ‘compensating’ services such as assistive technology, meals on wheels, practical help or provision of a safety alarm. However it should be noted that 6 participants in the control group received rehabilitation provided by an occupational and/or physical therapist.</p> <p>The study reports on service use during the first 3 months of the study (intervention n=29; control n=23):</p> <ul style="list-style-type: none"> <li>• Mean home visits per person during first 3 months – intervention n=78 (65 SD); control n=71 (82 SD).</li> <li>• Mean home visits per person per week – intervention n=7</li> </ul>	<p>intervention group over the whole 9 month study period, however this result was not statistically significant; treatment effect mean difference -0.4 (95% CI -0.8 to 0.1); p=0.14.</p> <p>Health related quality of life – social activities (self-reported, measured using COOP/Wonka, scale 1–5, 1=best)</p> <p>Three months: There was a mean difference in scores of 0.4 points on a self-reported measure of social activity in favour of the control group at 3 months, however this result was not statistically significant. Medium effect sizes were observed; adjusted effect size d=0.6; treatment effect mean difference 0.4 (95% CI -0.2 to 1.0); p=0.23.</p> <p>Nine months: There was a mean difference in scores of 0.1 points on a self-reported measure of social activity in</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>(5 SD); control n=6 (7 SD).</p> <ul style="list-style-type: none"> <li>• Mean hours home based service per person (travel time excluded) – intervention n=24.7 (21.7 SD); control n=20.1 (39.0 SD); reported as non-significant by the authors, p value not provided.</li> <li>• Mean hours home based service per person per week (travel time excluded) – intervention n=2.1 (1.8 SD); control n=1.7 (3.2 SD); reported as non-significant by the authors, p value not provided.</li> <li>• Distribution of home visits between professionals – There was a significant difference in groups in distribution of health professionals (p&lt;0.001).</li> <li>• Nurse – intervention 15.0 %; control 24.2%.</li> <li>• Auxiliary nurse – intervention 35.0%; control 43.2%.</li> <li>• Assistant – intervention</li> </ul>	<p>favour of the control group at 9 months, however this result was not statistically significant. Small effect sizes were observed; adjusted effect size d=0.4; treatment effect mean difference 0.1 (95% CI -0.5 to 0.8); p=0.65. Whole trial period of 9 months: There was an overall treatment effect of 0.3 on a self-reported measure of social activity in favour of the control group over the whole 9 month study period, however this result was not statistically significant; treatment effect mean difference 0.3 (95% CI -0.3 to 0.8); p=0.35.</p> <p>Health related quality of life – change in health (self-reported, measured using COOP/Wonka, scale 1–5, 1=best)</p> <p>Three months: There was a mean difference in scores of 0.1 points on a self-reported</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>22.7%; control 24.0%.</p> <ul style="list-style-type: none"> <li>• Physical therapist – intervention 9.9%; control 2.6%.</li> <li>• Occupational therapist – intervention 13.3%; control 0.2%.</li> <li>• Social educator – intervention 1.1%; control 1.5%.</li> <li>• Speech therapist – intervention 0.0%; control 0.0%.</li> <li>• Student – intervention 3.0%; control 3.1%.</li> <li>• Unknown profession – intervention 0.0%; control 1.2%.</li> <li>• Mean number of professions involved per person (excluding students) – intervention n=5; control n=3.</li> </ul> <p>The authors also report narratively that at 3 month follow-up there was a significantly higher number of</p>	<p>measure of change in health in favour of the control group at 3 months, however this result was not statistically significant; adjusted effect size <math>d=0.0</math>; treatment effect mean difference 0.1 (95% CI -0.2 to 0.5); <math>p=0.40</math>.</p> <p>Nine months: There was a mean difference in scores of -0.1 points on a self-reported measure of change in health in favour of the intervention group at 9 months, however this result was not statistically significant. Small effect sizes were observed; adjusted effect size <math>d=-0.4</math>; treatment effect mean difference -0.1 (95% CI -0.4 to 0.3); <math>p=0.66</math>.</p> <p>Whole trial period of 9 months: There was no overall treatment effect on a self-reported measure of change in health over the whole 9 month study period, however this was not statistically significant; treatment effect</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>co-interventions in the control group and that '...12 outpatient treatments in the control group versus 3 outpatient treatments in the intervention group (p=0.007), of which 10 of the outpatient treatments were physiotherapy ...' (p4), however it is unclear what exactly the differences between groups were.</p> <p><b>Outcomes measured:</b></p> <ul style="list-style-type: none"> <li>• Activity performance measured using the Canadian Occupational Performance Measure (Law et al., 2015, self-reported, sum score, 1–10, 10=best).</li> <li>• Activity satisfaction (Law et al. 2015, self-reported, measured using the Canadian Occupational Performance Measure, sum score, 1–10, 10=best).</li> <li>• Functional mobility measured in seconds using the Timed Up and Go (Podsiadlo et al. 1991).</li> </ul>	<p>mean difference 0.0 (95% CI -0.3 to 0.3); p=0.78.</p> <p>Health related quality of life – overall health (self-reported, measured using COOP/Wonka, scale 1–5, 1=best</p> <p>Three months: There was a mean difference in scores of -0.2 points on a self-reported measure of overall health in favour of the intervention group at 3 months, however this result was not statistically significant. Small effect sizes were observed; adjusted effect size d=-0.3; treatment effect mean difference -0.2 (95% CI -0.6 to 0.2); p=0.36.</p> <p>Nine months: There was a mean difference in scores of -0.2 points on a self-reported measure of overall health in favour of the intervention group at 9 months, however this result was not statistically significant. Small effect sizes were observed; adjusted</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Grip strength (measured in kilograms using the Jamar dynamometer).</li> <li>• Health related quality of life measured using 6 domains of the COOP/Wonka (Weel et al. 1993, self-reported, scale 1–5, 1=best. The 6 domains were physical fitness, feelings, daily activities, social activities, change in health, and overall health.</li> </ul> <p><b>Follow-up:</b> Follow-up assessments were conducted at 3 and 9 months.</p> <p><b>Costs?</b> No. Costs or resource use information are not reported.</p>	<p>effect size <math>d=-0.4</math>; treatment effect mean difference <math>-0.2</math> (95% CI <math>-0.6</math> to <math>0.2</math>); <math>p=0.40</math>. Whole trial period of 9 months: There was an overall treatment effect of <math>-0.2</math> on a self-reported measure of overall health in favour of the intervention group over the whole 9 month study period, however this result was not statistically significant; treatment effect mean difference <math>-0.2</math> (95% CI <math>-0.6</math> to <math>0.2</math>); <math>p=0.31</math>.</p>	

## Research question 4 – Findings tables - the views and experiences of people using services, their families and carers

### 1. Ariss S (2014) National audit for intermediate care: Patient reported experiences, 2014. Sheffield: University of Sheffield

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> To obtain views and experiences from people using intermediate care (reablement) by asking the following survey question, 'Do you feel that there is something that could have made your experience of the service better?'</p> <p><b>Methodology:</b> Survey.</p> <p><b>Country:</b> UK - England only.</p> <p><b>Source of funding:</b> Government.</p>	<p><b>Participants:</b> Service users and their families, partners and carers – people using intermediate care (bed based, home based and reablement).</p> <p><b>Sample size:</b> According to the abstract, responses were received from 1644 reablement users. However according to the main report, 207 responses were received for reablement services.</p> <p><b>Intervention:</b> Reablement.</p> <ul style="list-style-type: none"> <li>Description - In the broader audit, reablement is defined as 'community based services provided to service users in their own home'. These services help people recover skills and confidence to live at home, maximising their level of independence</li> </ul>	<p><b>Narrative findings - qualitative and views and experiences data –</b> NB. The report is published without page numbers so these cannot be provided with the quotes. Statements about ways that the service might be improved were coded into 8 distinct themes, which emerged from the data. They're listed here in descending order, starting with the one cited most frequently.</p> <p>Timing of visits Two main problems; the timing of visits was inappropriate or inconsistent and more time/greater frequency of visits were considered necessary, "Timings varied, between</p>	<p><b>Overall assessment of internal validity:</b> -</p> <p><b>Overall assessment of external validity:</b> ++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>so that their need for ongoing home care support can be appropriately minimised.</p> <ul style="list-style-type: none"> <li>• Delivered by - MDT but predominantly social care professionals.</li> <li>• Duration, frequency, intensity, etc.: For the majority of people, reablement lasts for up to 6 weeks (though there may be individual exceptions).</li> <li>• Key components and objectives of intervention - The objective is to maximise people's confidence and independence and minimize the need for ongoing home care.</li> <li>• Location/place of delivery - In peoples own homes/care homes.</li> </ul>	<p>7am-10.45am. This was not suitable for my circumstances. I was told this was not a timed service."</p> <p>Joined up and appropriate services This included continuity of carers, communication and coordination within and between services, timeliness or information about waiting times. Knowledgeability and information provision about other appropriate services, and discharge arrangements were also mentioned.</p> <p>Personal communication and attention Included lack of appropriate or consistent information about services or care, and lack of discharge information. Also lack of communication about visit times and changes to schedules. "A more proactive approach to</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>advising me about where to go for future help."</p> <p>Personal care Lack of consistency regarding standards of care and the tasks the reablement workers could be expected to deliver. Support for leaving the house was a common request: "On one occasion the member of staff did not help me to get undressed, I struggled on my own."</p> <p>Staffing Main concerns were lack of provider continuity, and shortage of staff. This impacts on many other important aspects of care, such as rushed visits, not enough time to share information, unpredictable and inappropriate visit times, inconsistent standards of care and lack of understanding about individuals' needs.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Length of service Some felt the service finished before they were ready. "I feel that the time spent with me was not enough and ended abruptly I am not better than when I left hospital."</p> <p>Therapy and assessment People wanted more physiotherapy. "In my particular circumstances a few more sessions at certain times might have helped me to make more secure progress. I had 2 sessions each week but found I could not sustain my confidence to re-store mobility with 2 sticks when I was at home alone. However I shall persevere."</p>	

**2. Gethin-Jones S (2013) Focus on the micro-relationship in the delivery of care. British Journal of Healthcare Assistants 7: 452-5**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The study aimed to find out what older people feel is important in terms of the delivery of their care.</p> <p><b>Methodology:</b> Qualitative.</p> <p><b>Country:</b> UK.</p> <p><b>Source of funding:</b> Not reported.</p>	<p><b>Participants:</b> Service users and their families, partners and carers.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Mean age 74.</li> <li>• Sex - 52% were female.</li> <li>• Disability - 75% were housebound.</li> </ul> <p><b>Sample size:</b> n=30.</p> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Delivered by - Assistant practitioners and trainee assistant practitioners.</li> <li>• Delivered to - People who have been discharged from hospital.</li> <li>• Duration, frequency, intensity, etc. - Average of 6 weeks.</li> </ul>	<p><b>Narrative findings - qualitative and views and experiences data -</b></p> <p>Three themes were identified through the analysis of the interview data:</p> <p>The need for social interaction beyond the delivery of clinical health care tasks.</p> <p>The importance of the 'non clinical' relationship with practitioners was the most strongly expressed theme. Strong neighbour like relationships were created with the reablement practitioners who came to know people's preferences and details about their families and interests. This was in stark contrast with the interaction experienced after handover to the home care service. "They rush in, do their tasks, change your pads</p>	<p><b>Overall assessment of internal validity:</b></p> <p>+</p> <p><b>Overall assessment of external validity:</b></p> <p>++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>and things and rush out again, and hardly say a word. It's like you're an animal and they are just changing the litter in a pet's cage" (p454).</p> <p>The need for consistent care staff in order to develop a working relationship. Consistency of staff made a significant contribution to the quality of relationships enjoyed in the reablement service. Reablement was provided by a consistent team of four, "Over the 6 weeks I got to know them and we had some good chats" (p454), unlike the home care service, 2 or 3 different care workers visited each day, "you just can't get to know them" (p454).</p> <p>The issue of consistency of staff wasn't just important for relationship building but also for protecting the dignity of people using the services,</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>"These people (carers) are doing really personal things to you. It's much more undignified getting a total stranger to come in and touch your private parts. It's very upsetting" (p454).</p> <p>The need for the older patient to feel they had some control over how their care was delivered.</p> <p>People valued being asked how they would like their care to be provided, including how their dignity could best be protected. If people felt involved in deciding how their care should be delivered, they felt valued and as though they had a more equal relationship with the carer.</p>	

**3. Ghortae H (2013) Reablement in Glasgow: Quantitative and qualitative research. Glasgow: Glasgow City Council**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<b>Study aim:</b> The researchers	<b>Participants:</b> Service users	<b>Narrative findings -</b>	<b>Overall assessment of</b>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>aimed to explore service user and staff views of a 6 week reablement programme.</p> <p><b>Country:</b> UK – Scotland – Glasgow.</p> <p><b>Methodology:</b> Mixed methods.</p> <p><b>Source of funding:</b> Not reported.</p>	<p>and their families, partners and carers - Only minimal details are provided regarding the sample of service users which the study included. It appears that the service may have been provided after discharge from hospital however this is not clear and there are no details on why participants had been admitted to hospital. Eligibility criteria for the service are not reported however the findings suggest that individuals with dementia, pelvic fractures or terminal illness were ineligible.</p> <p>The service was provided to individuals living in the north east of Glasgow. The majority of service users involved in the study appear to be female and over 60 years of age.</p> <p>The author notes that in some instances a family member may have completed surveys on behalf of service users.</p>	<p><b>qualitative and views and experiences data –</b> NB. The study reports on performance activity data in relation to service user outcomes (e.g. use of ‘mainstream’ home care, hospital admission, etc.) however as this does not meet the evidence criteria for question 4 regarding the effectiveness of reablement services these have not been extracted.</p> <p>Service user views and experiences (based on findings reported from quantitative telephone survey interviews and qualitative face to face interviews):</p> <p>Reablement process (p20-1) The 13 participants who took part in face to face interviews were asked - ‘When did someone come to speak to you about the Reablement Service in your</p>	<p><b>internal validity:</b> -</p> <p>This is a poor quality study that lacks methodological detail. The research was conducted with a very small group of participants and detail on who these participants were is missing. The findings are limited and are very often not reported in context.</p> <p><b>Overall assessment of external validity:</b> ++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p><b>Participants:</b> Professionals/practitioners – Only minimal details are provided regarding the sample of professionals which the study included. It appears that members of staff from a company providing the reablement service (Cordia Homecare, included ‘reablement home carers’, and ‘mainstream carers’ as well as an administrative member of staff and care co-ordinators); members of the North East Rehabilitation Team (included administrative staff, nurses, occupational therapists, physiotherapists, and support workers); and social work staff (including administrative staff, occupational therapists, social care workers, and team leaders).</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age – Exact details are unclear but it appears that</li> </ul>	<p>home?’ Less than 24 hours after discharge from hospital n=7. 24 hours after discharge from hospital n=3. 2 days after discharge from hospital n=1. 3 days after discharge from hospital n=0. More than 3 days after discharge from hospital n=1. Don’t know/not sure n=1.</p> <p>Did the service user understand what the service ‘was about’ after the first discussion they had had with reablement staff? Fully understood n=7; part understood n=4; did not understand at all n=1; not sure n=1.</p> <p>Had participants received written as well as verbal information in relation to the service? Yes n=6; no n=4; not sure n=3.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>the majority of service users involved were over the age of 60 as the study reports that participants for whom quantitative data were available, the ‘... majority at 64 (88%) were aged over 66 ...’ and for those sampled as part of the qualitative data collection ‘...ages ranged from 52 to 88 and over three quarters (10) were aged 70 plus ...’ (p20). No details are provided in relation to family members or professionals/practitioners.</p> <ul style="list-style-type: none"> <li>• Sex – Exact details are unclear but it appears that the majority of service users involved were female as the study reports that participants for whom quantitative data were available, ‘... 52 (71%) were female and 21 (29%) male ...’ (p20) and that and for those sampled as part of the qualitative data collection 8 were female and 9 were</li> </ul>	<p>Of the 6 participants who had received leaflets, 5 are reported to have found them helpful.</p> <p>Were reablement goals discussed with participants? Yes n=8; no n=3; not sure/no comment n=2.</p> <p>How confident were participants in achieving the goals that had been set? Confident n=11; not confident at all n=1; not sure n=1.</p> <p>The study reports that ten of these participants viewed goal-setting positively, with comments (see p21) such as:</p> <p>“fantastic”, “better because it makes you use yourself”, “great for self encouragement and stops deterioration”, “I was terribly bad at first but things have started to come together again”.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>male. No details are provided in relation to family members or professionals/practitioners.</p> <ul style="list-style-type: none"> <li>• Ethnicity – Exact details are unclear but it appears that the majority of service users involved were of white Scottish origin as the study reports that participants for whom quantitative data were available, ‘... almost three quarters at 53 (73%) were of white Scottish ethnic origin whilst 19 (26%) were not known and 1 (1%) was classed as white other British ...’ (p20) and that all of those sampled as part of the qualitative data collection were of white Scottish ethnic origin. No details are provided in relation to family members or professionals/practitioners.</li> <li>• Religion/belief – Not reported for service users, family members or professionals/practitioners.</li> </ul>	<p>The authors report that there was 1 interview participant who was unhappy with the service noting that he was reassessed soon after the interview and “... with his consent moved onto mainstream homecare as reablement was deemed to be unsuitable” (p21).</p> <p>Reablement support (p22-3) The study reports that both qualitative (face to face interviews) and quantitative (telephone survey interviews) research with service users demonstrated that help with mobility around the home, support with personal care needs, and help to prepare meals were the types of support most frequently provided. Although the levels of support required varied, most service users were supported in 4 or more areas. Other areas of support were</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Disability – Not reported for service users, family members or professionals/practitioners.</li> <li>• Long term health condition – Not reported for service users, family members or professionals/practitioners.</li> <li>• Sexual orientation – Not reported for service users, family members or professionals/practitioners.</li> <li>• Socioeconomic position – Not reported for service users, family members or professionals/practitioners.</li> </ul> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Service users – Exact numbers are unclear. The study reports that a total of 73 telephone survey interviews (quantitative research) were conducted with service users, as well as 4 face to face interviews (qualitative research) over a 6 month period with each</li> </ul>	<p>reported to enable service users to ‘feel safe’, ‘keep in touch with the community’, ‘have control over daily life’, and ‘help others care for you’ (p22). NB Although graphs are provided showing the numbers of service users receiving this type of support it is not possible to accurately determine the figures.</p> <p>The authors also report that both qualitative (face to face interviews) and quantitative (telephone survey interviews) research suggested that many service users had been able to ‘resume their usual activities’ (82% quantitative) and ‘do more things for themselves’ (74% quantitative; 69% qualitative) at the end of the programme.</p> <p>In relation to ‘ability to do more for themselves’, quantitative research also demonstrated that more than</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>service user (13 participants took part in these).</p> <ul style="list-style-type: none"> <li>Professionals/practitioners – Eleven professionals participated in focus groups (participants unclear – described as ‘cross agency reablement/mainstream staff’); 31 completed the questionnaire (included Cordia reablement home carers, social work staff, and members of staff from the North East Rehabilitation Service); and 11 members of staff from Cordia were interviewed (‘... mainstream staff involved in the handover of reablement at the end of the 6 week period’ p29).</li> </ul> <p><b>Intervention:</b> Reablement.</p> <ul style="list-style-type: none"> <li>Describe intervention - There are no details provided in relation to the intervention other than the description of it as a reablement service. The findings showed that the</li> </ul>	<p>half of those service users who were surveyed (n=41, 56%) felt that they needed less support at the end of programme. A third (n=25, 34%) are reported to have felt that they required the same level of support as before. One participant stated that they required a higher level of support whilst another reported that they no longer needed any help. Five participants did not provide an answer.</p> <p>In contrast, 2 participants included in the qualitative research (face to face interviews) reported that they had been hospitalised shortly after they had completed the reablement programme due to a deterioration in health. After discharge from hospital these participants required higher levels of home care.</p> <p>The author reports that</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>types of support most commonly provided related to mobility in the home, personal care needs, and preparation of meals. The service was also reported to enable service users to ‘feel safe’, ‘keep in touch with the community’, ‘have control over daily life’, and ‘help others care for you’ (p22).</p> <ul style="list-style-type: none"> <li>• Delivered by - The service is delivered by ‘reablement home carers’ working for Cordia Homecare. No details on experience or training level of these practitioners are provided.</li> <li>• Delivered to - The study does not report details on the population targeted or the services eligibility criteria however it appears that the service may have been provided after discharge from hospital however this is not clear and there are no details on why participants had been admitted to</li> </ul>	<p>service users who participated in the qualitative research (face to face interviews) were on the whole positive about the care they had received during the programme with 9 participants describing reablement staff as ‘very helpful and supportive’, and 1 participant reporting that staff were “quite supportive but more could have been done” (p23). One participant is reported to have stated “same staff as before” (p23).</p> <p>Reablement Satisfaction The study reports that the qualitative (face to face interviews) and quantitative (telephone survey interviews) research found that service user satisfaction was high during both the period in which the service was being provided and at the end of the programme.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>hospital. Eligibility criteria for the service are also not reported however the findings suggest that individuals with dementia, pelvic fractures or terminal illness were ineligible. The service was provided to individuals living in the north east of Glasgow. The majority of service users involved in the study appear to be female and over 60 years of age.</p> <ul style="list-style-type: none"> <li>• Duration, frequency, intensity, etc. - The study reports that the service was provided for 6 weeks however no further details in relation to frequency or intensity of the programme are provided.</li> <li>• Key components and objectives of intervention - Not reported.</li> <li>• Location/place of delivery - Care is provided to service users in their homes.</li> </ul>	<p>Participants included in the qualitative research (face to face interviews) stated that they were:  Very satisfied 69%; satisfied 23%; neither satisfied nor dissatisfied 0%; dissatisfied 8%; very dissatisfied 0%; not sure/no comment 0%.</p> <p>Comments from these participants included:  “staff setting the goals to work towards is good”,  “everyone very helpful and friendly”, “can't fault it”,  “would rather have dinner earlier”, “so far but would like consistency as to when the carer comes in the morning”.</p> <p>The author stresses that the final 2 comments were made by service users who were satisfied with the service overall but wanted to highlight specific concerns they had.</p> <p>Participants included in the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>quantitative research (telephone survey interviews) stated that they were:  Very satisfied 84%; satisfied 10%; neither satisfied nor dissatisfied 1%; information not provided 5%.</p> <p>Comments from these participants included:  “I feel more confident and the carers were fantastic!”  “Delighted with service, all workers were great, carers &amp; OT's”  “The OT's visiting could not have been nicer. Has also improved my independence”  “Very positive experience, thanks to everyone for their help”  “If all the workers are like the reablement carers then we have nothing to worry about, very satisfied with service. I feel more confident with doing a lot more myself”  “All great although there were a lot of different girls in</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>house. Nothing seems to be consistent”</p> <p>“One of the carers was exceptional and referred me on for other services. But found other carers to be quite unhelpful”</p> <p>“Relatively happy but did state that was not happy with the last carer who attended as she only stayed half the time that she should have”</p> <p>Service users were asked as part of the qualitative research (face to face interviews) to describe their current health status at the third stage of the research (not clearly stated what point this relates to). Six reported that their ‘... health had deteriorated but they were coping ok at home ...’ (p25), 4 stated that their health was the same, and 2 reported that their ‘... health had improved and that they were coping well ...’ (p25). One participant</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>had dropped out of the study and had begun to receive 'mainstream' home care. Transition from Reablement to Mainstream Home Care/ Independence</p> <p>Participants included in the quantitative research (telephone survey interviews) who were now in receipt of 'mainstream' home care (n=7) or were 'independent in the community' (n=5) were asked about their experiences. Responses from those receiving 'mainstream' home care varied with 4 reporting the process to be 'smooth and easy', one stating that it was 'partially smooth with difficulties' and 2 others reporting that it was difficult.</p> <p>Service users who had experienced difficulties commented that:            "I was wary at the start",            "there were mixed messages</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>about the meals". An unpaid carer who participated in this stream of research is also quoted by the author to show that some service users had experienced difficulties:</p> <p>"Could have been better communication re. transfer to mainstream homecare. Daughter was unaware her mother had reached Reablement potential and was transferring. They were initially told they would be on Reablement for 6 weeks, but it only lasted 4 which caused the daughter problems" (p26).</p> <p>As part of the qualitative research, focus group discussions were held with 11 staff who had been nominated by the multidisciplinary reablement group. The group was asked to identify 'forces working towards reablement' and 'forces working against</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>reablement' and to weight these according to their importance.</p> <p>Practitioner views The author only reports those 'forces working against reablement' which participants identified. The group was then asked to 'turn' these into solutions or 'forces working towards reablement'. These have been quoted verbatim as it is very often difficult to understand the meaning of each 'force' (see p28): Problem – 'Increased workload for Rehab team - no resources. Since reablement 30% increase. Cordia Home Care also feel the same ...' Solution – 'Use Change Fund money' Problem – 'There is a challenge to fit into other systems.' Solution – 'Use Joint systems or even partial joint'.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Problem – ‘Communication’.  Solution – ‘Want to know more about processes across agencies who’s responsible for what. Training / shadowing / pdp.’</p> <p>Problem – ‘Cordia - more stress keeping reablement clients who need palliative care or are terminally ill. Sometimes up to 5 days.’  Solution – ‘Social Work Services should screen out appropriate reablement cases. Should also flag up on Social Care Direct system that case is not appropriate for reablement. Cordia co-ordinator should be able to phone Reablement team to say that a specific case is mainstream and not reablement’.</p> <p>Problem – ‘Perception across care providers is different if client appropriate for Reablement’.  Solution – ‘Need to talk to each other more’.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Problem – ‘Electronic trigger which is faceless/ nameless does screening’.</p> <p>Solution – ‘Can’t do anything about this’.</p> <p>Problem – ‘Duplication of work’.</p> <p>Solution – ‘Need to talk to each other more’.</p> <p>Problem – ‘Tip of the iceberg - currently only a few people benefiting from reablement’.</p> <p>Solution – ‘Resource implications’.</p> <p>Problem – ‘Bureaucracy/ paperwork. Certain processes cannot be dealt with until gone through appropriate people and channels’.</p> <p>Solution – ‘Streamline the whole thing. Should be able to phone each other’.</p> <p>Problem – ‘Cordia - work time very unrealistic. Especially Fridays - when emergency cases sometimes double and have normal reablement cases coming through as</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>well. The system bottlenecks and staff are working flat out'.  Solution – 'Resource implications. Resolve issues at hospital end i.e. why does system bottleneck on a Friday?'</p> <p>Problem – 'Guidelines change constantly can cause confusion/ frustration. Aware that reablement is new and this bound to happen'.  Solution – 'Each agency is involved in Operational Meeting where changes should be discussed and passed on to others. Steering Group also a channel for discussion and circulation of information'.</p> <p>Problem – 'Varying systems across agencies'.  Solution – 'Joint systems or partial join'.</p> <p>Problem – 'Too many procedures/criteria'.  Solution – 'Speak to each other'.</p> <p>Problem – 'dual client - who</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>provides OT?’  Solution – ‘Discuss at Operational Meeting to resolve’.  Problem – ‘Cordia - internal problems whether a case is mainstream or reablement’.  Solution – ‘Area Service Manager to deal with individual situations.  Reablement staff should be able to talk to each other and resolve whether a case lies with mainstream or reablement home care’ (p28).</p> <p>These findings were then used to ‘... compile questionnaires for the next phase of the staff consultation’ (p28). The author emphasises that the main challenges identified were a higher workload, duplication of work and ‘bureaucratic’ paperwork, a lack of clarity regarding roles and responsibilities, guidance and policy, screening issues,</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>bottlenecking, and 'varying cross agency systems'. (p 28)</p> <p>Fifty-six members of staff were also asked to complete a Survey Monkey questionnaire in July 2012. This included Cordia reablement home care staff, as well as Social Work Services; and 9 (29%) from North East Rehabilitation Service.</p> <p>Face to face interviews were also conducted with 11 'mainstream' staff members at Cordia who had involvement in the transfer of service users from the reablement programme at the end of the 6 week period. These participants were specifically asked about the handover process.</p> <p>'What is working well?'</p> <p>The author reports that all types of staff understood</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>clearly the aims and objectives of the service and quote 3 participants to evidence this:</p> <p>'Helping people and getting them back on their feet &amp; getting their independence. Helping with confidence and self-esteem. Striving for total independence but in reality some won't get this' (p29).</p> <p>'To establish an appropriate level of homecare service following a period of reablement. That level of service may be maintained or decreased depending on patients needs. To promote independence' (p29, North East Rehabilitation Service members of staff).</p> <p>'To work with service users to improve their mobility/confidence to carry out tasks on their own. There would then not be a need for</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>the home care service to assist with these tasks, therefore reducing the budget' (p29, social work services member of staff).</p> <p>The author goes on to emphasise that goal setting was generally viewed positively: 'I am able to know that the homecarers are facilitating reablement process and progressing patient goals on a regular basis. The patient is then receiving regular and consistent input to progress.' (Occupational Therapist - North East Rehabilitation Service)</p> <p>Over half of the staff participants (54%) are reported to have rated the service as 'excellent or good' with 92% of Cordia staff, 33% of social work staff and 22% of North East Rehabilitation Service staff giving this</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>rating. The author notes that when these participants were asked 'what was working well'; 100% of those reablement staff working at Cordia were able to make a positive suggestion; whilst only 77% of social work staff and 44% of North East Rehabilitation Service could do so.</p> <p>Positive statements made regarding the service are reported to mainly relate to the way in which the service empowered service users to gain independence, the ability to provide intensive cross-agency support that helped service users, and the 'quality input' (p29).</p> <p>"Job satisfaction is great. I enjoyed the job previously but much more satisfying with reablement. You get to see the final outcome with the service user. I feel part of the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>process in helping someone. Your opinion counts. I feel part of a bigger team, working with other agencies - I didn't have this before" (p29-30 Cordia member of staff).</p> <p>'Reablement OTs have a good relationship with Cordia. I feel that I have had good outcomes with service users' (p29, Occupational Therapist, social work services).</p> <p>Participants are also reported to have felt that the reablement service had enabled them to develop new skills and had been received well by service users and their families with 52% reporting that feedback had been 'mostly favourable' and 26% reporting that it had been 'partially favourable'. Participants reportedly felt that 'partially favourable' feedback was often a result of the service user's</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>vulnerability or the complexity of their case.</p> <p>Participants reported that service users and their families had expressed their appreciation of the service:</p> <p>'Thanks &amp; gratitude received from clients and family. They show their appreciation when service has worked &amp; they don't need any further help. Clients are well satisfied by this achievement' (p30, no details provided in relation to source of quote).</p> <p>'Family quite happy with service, so mostly favourable. They don't want person sit about all day - happy they can do things for themselves' (p30, no details provided in relation to source of quote).</p> <p>The author reports that reablement training was viewed positively by staff however '... there was also a</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>strong consensus that it needed to be ongoing to keep up with any changes or updates within the service' (p30, author).</p> <p>The author emphasises that all participants from Cordia had viewed their training positively:</p> <p>'... Without training it would have been impossible to take a step back. You get put into the position service users are in &amp; then it makes you think different on how your approach to them would be. - I use it in my home life as well now' (p30, no details provided in relation to source of quote).</p> <p>'Wearing body suits gives concept service user might be feeling or going through. How would you approach this situation? And then deal with it appropriately' (p30, no</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>details provided in relation to source of quote).</p> <p>Participants were also asked to rate the methods (other than training) by which information on reablement had been provided to them:</p> <p>Written information circulated - Excellent n=10; good n=6; average n=4; fair n=1; poor n=3; not sure/not known n=4; not applicable n=1.</p> <p>Briefings/meetings - Excellent n=11; good n=5; average n=5; fair n=4; poor n=1; not sure/not known n=2; not applicable n=2.</p> <p>Supervision sessions - Excellent n=7; good n=4; average n=3; fair n=1; poor n=1; not sure/not known n=2; not applicable n=11.</p> <p>Personal development plans - Excellent n=3; good n=3; average n=3; fair n=1; poor n=2; not sure/not known n=2; not applicable n=16.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Work colleagues - Excellent n=14; good n=12; average n=4; fair n=0; poor n=1; not sure/not known n=0; not applicable n=0.</p> <p>Conferences/seminars - Excellent n=1; good n=2; average n=3; fair n=1; poor n=1; not sure/not known n=2; not applicable n=19.</p> <p>Other - Excellent n=5; good n=4; average n=1; fair n=0; poor n=1; not sure/not known n=2; not applicable n=16.</p> <p>‘What needs to improve?’ The author reports that there was consensus regarding ‘some duplication of work’ both internally and between agencies (p31); with Cordia administrative staff noting that identical referrals sometimes came from the same staff member and other agency staff raising the issue of duplicate records on a variety of databases.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>The author also reports that other concerns included duplicate assessments by reablement teams and stroke teams, and reablement and 'mainstream' Cordia staff visiting a service user at the same time.</p> <p>Other issues were reported by agency:  Social work - Occupational therapists and social care workers are reported to have felt that clearer roles and responsibilities were needed; social care workers suggested that assessment forms and communication should be improved; occupational therapists felt that there should be more policies and procedures. Occupational therapists are also reported to have felt that reablement work gave them more autonomy than their previous role had '... which needed to change' (p31,</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>author); and reablement administrative staff were reported to be often ‘... pulled away from reablement work to cover phones/ reception for wider OPPD Team’ (p32, author).</p> <p>Cordia reablement home carers - The author reports that reablement home carers felt that screening was an issue with ‘inappropriate’ referrals for service users who did not meet service criteria such as those with dementia; terminal illness or pelvic fractures; they were also reported to have felt that occupational therapy input was ‘too slow’ and that occupational therapists did not consistently update diaries. There were also concerns regarding the medical information as ‘... home carers were having to access chemist’s to get emergency set up for medical</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>provision; does it boxes on hospital discharge did not always display relevant information; and pharmacy names were often missing from paperwork' (p32). It was also suggested that the service needed to find a way in which to improve the way in which service users were encouraged to take their medication.</p> <p>Other issues raised in relation to reablement home carers included the need for sensitivity when starting reablement and the importance of informing service users in advance of changes; the fact that higher numbers of 'mainstream' service users meant that home carers sometimes had to spend less time with reablement clients; generally low numbers of reablement service users at the time of the research and Cordia staff</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>are reported to have felt that they were being 'pulled' towards 'mainstream' care work.</p> <p>Cordia 'mainstream' home carers - Home carers are reported to have expressed concern regarding handovers between reablement and their own team and it was suggested that the 2 teams should meet face to face at handover to ensure that information was passed on and that reablement diaries might still be useful to mainstream home carers because they contained detailed information on any aids and adaptations in use. Missing medical information at the handover was also raised as an issue.</p> <p>This group were also reported to have been frustrated at the fact that they were not allowed to attend</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>reablement meetings or to undertake reablement training. Although the group is reported to be somewhat cynical with regards to what could be achieved in 6 weeks, they also suggested that it was time constraints which prevented them from providing similar levels of support to reablement staff. It is also reported that some of this group felt that workload issues were a result of the failure to replace staff who had been reassigned to the reablement service.</p> <p>North East Rehabilitation Service - This group reportedly raised a number of concerns regarding difficulties in contacting reablement workers to discuss service user goals or assessments; as well as difficulties in arranging joint visits with reablement home care co-ordinators; poor</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		communication between their own team and other reablement staff; time-consuming paperwork and problems in making copies of assessments; a lack of clarity on home carer roles and the level of training they had received; and a lack of North East Rehabilitation Service staff resources which impacts on caseloads, first visits to service users and team meetings. Some participants are also reported to have felt that a separate reablement service should have been established instead of a joint social work and North East Rehabilitation Service.	

**4. Hjelle KM, Tuntland H, Førland O et al. (2016) Driving forces for home-based reablement; a qualitative study of older adults' experiences. Health and Social Care in the Community 24, doi 10.1111/hsc.12324**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<b>Study aim:</b> To describe how older adults experienced participation in reablement.	<b>Participants:</b> Service users and their families, partners and carers - Older people with	<b>Narrative findings - qualitative and views and experiences data –</b>	<b>Overall assessment of internal validity:</b> ++

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Methodology:</b> Qualitative study. Semi structured interviews with 8 older adults.</p> <p><b>Country:</b> Norway.</p> <p><b>Source of funding:</b> Government - Regional Research Funds Western Norway fund the researchers. There is no further detail about the funding of the project.</p>	<p>experience of reablement.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - 64-92 years.</li> <li>• Sex – Four men, 4 women.</li> <li>• Disability - Diagnosis 1. Man, heart attack. 2. Woman, back pain, transient ischaemic attack. 3. Woman, hip fracture, osteoporosis. 4. Man, pelvis fracture, pelvis fracture, hemokromatose, glaucoma, contracture of left hand. 5. Man, stroke, heart attack, diabetes, asthma. 6. Man, stroke, knee arthrosis, diabetes. 7. Woman, hip fracture, osteoporosis. 8. Woman, pelvis fracture, rheumatoid arthritis, osteoporosis.</li> </ul> <p><b>Sample size:</b> n=8.</p> <p><b>Intervention:</b> Reablement.</p> <ul style="list-style-type: none"> <li>• Description - Provided to people in their own homes involving person centred, joint goal setting,</li> </ul>	<p>Four themes emerged:</p> <p>My willpower is needed. Several described their willpower as being an important factor in the reablement process. The willpower to manage daily tasks and exercises evolved as they recovered.</p> <p>Participants wanted to be as good as they were before their accident or illness and knew they had to assume responsibility for this: "It depends on the willpower. Yes, that is what you need, the willpower ... if you sit down, then you're not going anywhere. You must have the drive to come ahead in life. Goal-setting, has been important and my willpower to exercise" (Participant 8, p5). Goal setting was perceived to be crucial to returning to their former abilities.</p>	<p><b>Overall assessment of external validity:</b></p> <p>++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>physiotherapy, occupational therapy, adaptations and exercise programmes.</p> <ul style="list-style-type: none"> <li>• Delivered by - Occupational therapists, physiotherapists and home care personnel.</li> <li>• Delivered to - Older people applying for and being referred to home based services.</li> <li>• Duration, frequency, intensity, etc.: The aim appears to be improving independence and strength and the ability to carry out daily activities inside and outside the home. Unlike the NAIC description of reablement (and most reablement services in the UK), this reablement service lasts up to 3 months. As well as home care personnel assisted training, a minimum of 1 hour per week of physiotherapist or occupational therapist assisted training is provided. Programmes are tailored to</li> </ul>	<p>Being with my stuff and my people.</p> <p>It was important to participants to be in their own home during reablement, able to receive visits from neighbours and families and take part in leisure and social activities. With reablement being delivered at home, this gave people autonomy and independence. It meant they could choose when to do their exercises and practice their daily activities in their own time instead of having to attend appointments if the intervention was delivered elsewhere. "when you are at home you can do the exercises when you are ready for it, you have the control yourself" (Participant 1, p6). They also pointed out they could adjust their everyday lives and routines according to how they were improving.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>the person's goals so the rehabilitation plans vary. They may include - training in activities of daily living including dressing, food preparation and visiting friends at a day club or being able to knit. Adaptations such as advice on appropriate assistive technology or adapting the activity or environment - exercise programmes e.g. indoor or outdoor walking, climbing stairs and performing exercises to improve strength or balance. The exercise was incorporated into daily routines and the person was given an explanatory manual and encouraged to train on their own.</p> <ul style="list-style-type: none"> <li>• Key components and objectives of intervention - The intervention starts with an interview conducted by an occupational therapist or physiotherapist where the</li> </ul>	<p>The reablement team is important for me The team provided essential support and participants felt it was a real partnership.</p> <p>Two sub themes were identified – Encouragement to take responsibility in daily training. Daily training included physical exercises and also learning to do every day activities. The reablement team doesn't perform the tasks <i>for</i> people, rather they facilitate the person to carry them out themselves. Respondents saw the benefit of this and felt a sense of freedom, being able to carry out activities for themselves instead of waiting for staff to do things for them, "I have the responsibility . . . and you feel a little freer in a way. You can do as you did before the illness. I used to go for a walk every day, however I don't go</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>rehabilitation plan is developed together with the participant based on the identified activity goals. Thereafter, an integrated multidisciplinary team with shared goals guided the participant during the whole rehabilitation period. During the rehabilitation period where assisted training is carried out by home care personnel, at least an hour of physiotherapist or occupational therapist assisted training is provided every week. Adaptations and exercise programmes are also provided during the intervention.</p> <ul style="list-style-type: none"> <li>• Location/place of delivery - People's own home.</li> </ul>	<p>down to the main road yet, but I walk a little further each day. It is the freedom to decide yourself when you want to go for a walk. It was like a new life when I could go outside." (Participant 8, p6).</p> <p>Encouragement to feel confident doing everyday activities on one's own. The reablement service encouraged people and supported them to regain confidence in everyday activities. Reablement workers adjusted the support they provided according to how the person was feeling. "They supported me in the beginning, so I showered myself while someone from the reablement service was here. I got a chair to sit on to be more secure when showering. They were here until I felt secure to shower myself" (Participant 7, p6).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>Reablement workers were seen as the driving force behind people's recovery. However for some this meant that at the end of the reablement period they were no longer motivated and stopped doing their exercises when there were no reablement workers around to encourage them.</p> <p>Training in physical exercises, not everyday activities</p> <p>The reablement team perceived the support with activities of daily living to be 'training' but the respondents generally didn't. They viewed the physical exercises as training but felt that the support with activities of daily living was simply 'practicing' because this was something they'd done throughout their lives (e.g. showering) and just needed help to become confident in the task again -</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		or to find a new way of carrying it out.	

**5. Wilde A and Glendinning C (2012) 'If they're helping me then how can I be independent?' The perceptions and experience of users of home-care re-ablement services. Health and Social Care in the Community 20: 583-90**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> To report on the interview study component of reablement service users and carers (part of a wider multi-method study of reablement). Considers the immediate and longer term impact of the service for the recipients and identifies potential barriers to optimal outcomes for these stakeholders.</p> <p><b>Methodology:</b> Qualitative study.</p> <p><b>Country:</b> UK.</p> <p><b>Source of funding:</b> Not reported.</p>	<p><b>Participants:</b> Service users and their families, partners and carers.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - 74% of the 34 Service users were over 65 years; 60% of carers also over 65 years.</li> <li>• Sex - 65% of 34 service users were female, and 70% of carer sample were female.</li> <li>• Ethnicity - 9% of service users were black or from a minority ethnic background.</li> <li>• Long term health condition - Although not given, in general the study included people being discharged from hospital after stroke or</li> </ul>	<p><b>Narrative findings - qualitative and views and experiences data –</b></p> <p>Users and carers may have unrealistic expectations, especially if they have prior experience of home care. Very few had received clear information while they were still in the care of the NHS, or at referral. If they were unclear that the service was designed to help them do things for themselves, they might experience the service as neglectful. Those who had suffered from a debilitating stroke or injury were more appreciative of what the service was about, and its outcomes.</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>injury, and also those referred from the community, who were likely to have ongoing long term conditions and may have had usual health care before.</p> <ul style="list-style-type: none"> <li>• Socioeconomic position - 59% of service users lived alone.</li> </ul> <p><b>Sample size:</b> 34 users of reablement services who had received several weeks of the service, but had not yet been transferred to any ongoing service (so as to reduce confusion between services under discussion).</p> <p><b>Intervention:</b> Reablement services. Four of the 5 were new specialised services, 1 was incorporated into existing in-house home care.</p> <ul style="list-style-type: none"> <li>• Description - Intensive short-term reablement support to maximise person's capabilities to maximise practical skills and ability to</li> </ul>	<p>Goal setting was also unfamiliar to users, and those recovering from stroke and trauma adapted better than did those with ongoing debilitating long-term conditions.</p> <p>Those with a permanent disability or a progressive long-term condition found goal-setting did not take account of fluctuating conditions and abilities, and sometimes goals could not be achieved because other services/equipment could not be accessed. Goals then became a focus of frustration. Goal-focused reablement also met with resistance among people of ethnic backgrounds where caring was seen as the desirable norm.</p> <p>Interviewees wanted help to get out of the house -</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>maximise social participation.</p> <ul style="list-style-type: none"> <li>• Delivered by - Trained reablement staff (some new to home care, others with experience of usual home care).</li> <li>• Delivered to - Adult social care clients. All 5 services started with referrals from hospital discharge, intermediate care or the community, but gradually became more inclusive, acting as first intake service for all referrals 18+. Selection criteria (e.g. possibly not offering service to those with advanced dementia) operated but were not made explicit.</li> <li>• Duration, frequency, intensity, etc.: All services aimed to offer 6 weeks' reablement, but there was some flexibility to extend this in individual cases.</li> <li>• Key components and objectives of intervention -</li> </ul>	<p>reablement did not offer support for social contact. Lack of flexibility imposed unsocial bedtimes, for example. Many appreciated the actual providers, and felt their loss at the end of 6 weeks.</p> <p>Carers were sometimes helped to learn new ways of managing needs of the person, but some did not recognise the purpose of the intervention, or feel it had helped them.</p> <p>Overall, the study concluded that people attach different meanings to 'independence' and that benefits of reablement practice are greatest for those temporarily disabled, who can expect to recover (rather than those with long-term degenerative illnesses).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>Intensive short-term reablement support to maximise person's capabilities to maximise practical skills and ability to maximise social participation. Person may then not need home care, or could be referred to more long-term, but hopefully lower level, support. Preventive element to reduce dependency.</p> <ul style="list-style-type: none"> <li>• Location/place of delivery - The person's home.</li> </ul>		

#### Research question 4 – Findings tables – Health, social care and other practitioners views and experiences

##### 1. Rabiee P and Glendinning C (2011) Organisation and delivery of home care re-ablement: What makes a difference? Health and Social Care in the Community 19: 495–503

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<b>Study aim:</b> To explore the organisation, content and features of reablement services	<b>Participants:</b> Professionals/practitioners - Service managers (8 from 5	<b>Narrative findings - qualitative and views and experiences data –</b>	<b>Overall assessment of internal validity:</b> +

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>in 5 local authority sites, to consider what factors have the ability to enhance or detract from effectiveness.</p> <p><b>Methodology:</b> Qualitative study.</p> <p><b>Country:</b> UK.</p>	<p>sites interviewed) and frontline providers (focus groups).</p> <p><b>Sample size:</b> Service managers (8 from 5 sites interviewed) and frontline providers (37 took part in 5 focus groups).</p> <p><b>Intervention:</b> Reablement services. Four of the 5 were new specialised services, 1 was incorporated into existing in-house home care.</p> <ul style="list-style-type: none"> <li>• Description - Intensive short-term reablement support to maximise person's capabilities to maximise practical skills and ability to maximise social participation.</li> <li>• Delivered by - Trained reablement staff (some new to home care, others with experience of usual home care).</li> <li>• Delivered to - Adult social care clients. All 5 services started with referrals from</li> </ul>	<p>The following were identified as internal factors contributing to service effectiveness:</p> <ul style="list-style-type: none"> <li>• Service user characteristics (e.g. ability to benefit; motivation).</li> <li>• Staff commitment, attitudes and skills (staff new to home care generally more receptive to model).</li> <li>• Ability of staff to be flexible, prompt, offer continuity of care.</li> <li>• Sound proportionate staff recording.</li> <li>• Access to complementary services, especially occupational therapy for equipment.</li> </ul> <p>The following external factors were identified as contributing to service effectiveness:</p> <ul style="list-style-type: none"> <li>• Wide understanding about purpose and vision of service.</li> </ul>	<p>This is a convincing study which would have scored higher if more of the internal workings of the analysis had been reported.</p> <p><b>Overall assessment of external validity:</b> ++</p> <p>Five disparate local authorities suggest this study is probably generally applicable to similar services in the United Kingdom.</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>hospital discharge, intermediate care or the community, but gradually became more inclusive, acting as first intake service for all referrals 18+.</p> <p>Selection criteria (e.g. possibly not offering service to those with advanced dementia) operated but were not made explicit.</p> <ul style="list-style-type: none"> <li>• Duration, frequency, intensity, etc.: All services aimed to offer 6 weeks' reablement, but there was some flexibility to extend this in individual cases</li> <li>• Key components and objectives of intervention - Intensive short-term reablement support to maximise person's capabilities to maximise practical skills and ability to maximise social participation. Person may then not need home care, or could be referred to more long-term, but hopefully</li> </ul>	<ul style="list-style-type: none"> <li>• Access to specialist skills.</li> <li>• Capacity in home care services for intensive intervention. Nesting the service (in 1 local authority) within the existing home care service was less successful, as staff were expected to deliver a more intensive service within the usual time allotted. Staff new to home care appeared more receptive to the new approach.</li> <li>• Capacity within home care services.</li> </ul>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	lower level, support. Preventive element to reduce dependency. <ul style="list-style-type: none"> <li>• Location/place of delivery - Person's home.</li> </ul>		

## Research question 4 – Critical appraisal – Effectiveness

### 1. Dundee City Council and Tayside NHS (2010) Home care enablement service: Evaluation. Dundee: Dundee City Council

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<b>Study aim:</b> The study objectives are described as – <ul style="list-style-type: none"> <li>• ‘Determine the views of service users and other stakeholders, of the service.</li> <li>• Explore the impact of working in a different way on the home care staff.</li> <li>• Establish if enablement had a significant impact on speed of discharge from hospital.</li> <li>• Demonstrate a comparison between the service users who had completed the enablement service, and those of a trial group of service users who were</li> </ul>	<b>Quantitative component:</b> The collection of data about the level of care need (intervention and control)  <b>Are participants (organisations) recruited in a way that minimises selection bias?</b> Unclear. The intervention participants were apparently selected ‘at random’ but there is no explanation about how this was done e.g. computer generated.  <b>Are measurements</b>	<b>Does the study’s research question match the review question?</b> Yes.  <b>Has the study dealt appropriately with any ethical concerns?</b> No. There's no mention of ethical approval and no discussion about obtaining consent to participate in the study.  <b>Were service users involved in the study?</b> Yes. They completed satisfaction questionnaires after the period of enablement but	<b>Overall assessment of internal validity:</b> -  <b>Overall assessment of external validity:</b> ++

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>discharged from hospital during the same period of time during the previous year.</p> <ul style="list-style-type: none"> <li>• Draw from the experience in order to inform the implementation of an enablement approach across the whole of home care' (p4).</li> </ul> <p><b>Methodology:</b> Mixed methods. Qualitative - focus groups, surveys and quantitative - analysis of data about required number of home care hours.</p> <p><b>Qualitative component:</b> Focus groups with practitioners.</p> <p><b>Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question?</b> Partly. Limited to focus groups. Individual interviews may have been more appropriate, particularly for eliciting the views of people using the enablement service.</p>	<p><b>appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?</b> Yes. The only measurement is 'care hours needed'.</p> <p><b>In the groups being compared (exposed versus non-exposed; with intervention versus without; cases versus controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?</b> Unclear. We have no information about the participants (except that they have been discharged from hospital and have care needs) so it is impossible to tell whether the control and intervention groups have the same characteristics.</p>	<p>service users were not involved in the design or conduct of the study.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. Although note that the enablement service only took referrals from the hospital social work team - no community referrals.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes.</p> <p><b>Are the study outcomes relevant to the guideline?</b> Yes. Number of care hours</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Is the process for analysing qualitative data relevant to address the research question?</b> Unclear. Analysis is not described.</p> <p><b>Is appropriate consideration given to how findings relate to the context, such as the setting, in which the data were collected?</b> No. There is no discussion about this.</p> <p><b>Is appropriate consideration given to how findings relate to researchers' influence; for example, though their interactions with participants?</b> No. No discussion about this.</p>	<p><b>Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?</b> Yes.</p> <p><b>Is the mixed-methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed-methods question?</b> Partly. Interview data would have provided more in-depth qualitative evidence.</p> <p><b>Is the integration of qualitative and quantitative data (or results) relevant to address the research question?</b> Unclear. No explanation provided about the integration of the qualitative and quantitative components.</p>	<p>needed.</p> <p><b>Are the views and experiences reported relevant to the guideline?</b> Yes.</p> <p><b>Does the study have a UK perspective?</b> Yes – Scotland.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Is appropriate consideration given to the limitations associated with this integration, such as the divergence of qualitative and quantitative data (or results)?</b> No. There is no discussion about the limitations of the study design.</p>		

**2. Glendinning C, Jones K, Baxter K et al. (2010) Home Care Re-ablement Services: Investigating the longer-term impacts (prospective longitudinal study). York: Social Policy Research Unit, University of York**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To examine:</p> <ol style="list-style-type: none"> <li>Whether home care reablement improved outcomes for people by giving them greater independence, when compared with conventional home care services.</li> <li>If the improved outcomes lasts over time.</li> <li>The cost-effectiveness of reablement.</li> </ol> <p><b>Methodology:</b> Mixed methods. Quantitative data collection and analysis for users outcomes;</p>	<p><b>Quantitative component:</b> Four outcome measures assessed via questionnaires administered face-to-face on entry to reablement (T1), on discharge from reablement (T1 + R) and follow up (T2). Note that service use information was also collated from local authority records and postal questionnaires but this element of the study is reviewed as part of the cost effectiveness analysis.</p>	<p><b>Does the study's research question match the review question?</b> Yes. To examine:</p> <ol style="list-style-type: none"> <li>Whether home care reablement improved outcomes for people by giving them greater independence, when compared with conventional home care services.</li> <li>If the improved outcomes lasts over time.</li> <li>Cost-effectiveness of reablement.</li> </ol>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>qualitative data collection and analysis for views and experiences of users and care professionals. Quantitative data analysis Univariate analysis (paired t-tests, chi-squared tests and binomial tests) and multivariate analyses. Data analysis were adjusted on baseline characteristics. Multivariate regression analyses were performed employing both a fixed and random-effects model to explore outcome changes between baseline and the 12 month follow-up.</p> <p><b>Country:</b> United Kingdom. Nine local councils in the United Kingdom (Brighton and Hove, Croydon, Hampshire, Haringey, Leicestershire, Lincolnshire, North East Lincolnshire, Nottinghamshire and Wirral Borough).</p> <p><b>Qualitative component:</b> Interviews with people using reablement and their carers</p>	<p><b>Are participants (organisations) recruited in a way that minimises selection bias?</b> No. Participants were not randomised and they came from different locations. The populations from which they were recruited are therefore likely to be different. All the reablement services are likely to differ (different aims/referral routes) as are all the control interventions (home care). A particular source of bias is the differences in between the groups at baseline. For example 70% of the reablement group were referred on discharge from hospital, which is not true of control participants. Researchers could at least have matched the 2 groups of participants. In addition, people with severe dementia and people with end of life care needs were excluded from the study and in 1 site, people with learning disabilities were excluded, which introduces</p>	<p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. NHS ethical approval for the study was obtained, as well as approval from the Association of Directors of Adult Social Services Research Group. Both verbal and written consent sought from participants.</p> <p><b>Were service users involved in the study?</b> No.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. To examine the immediate and long term benefits of home care reablement when compared with conventional home care services and the cost effectiveness of reablement.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. People aged over 65 years receiving home</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question?</b> Partly. Face-to-face interviews with people using reablement, carers and managers to elicit their views and experiences about reablement services. Note that 1 weakness is that the service users interviewed for the qualitative component had not participated in the comparative part of the study so views and experiences could not be connected with outcome data. Similarly the observations were not conducted during the delivery of care to interview respondents so an opportunity for triangulation was missed.</p> <p><b>Is the process for analysing qualitative data relevant to address the research question?</b> Yes. The data generated was analysed using a process of data reduction, data display, and conclusion drawing</p>	<p>possible bias and limits the applicability of findings.</p> <p><b>Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?</b> Yes. All outcome measures validated.</p> <p>1. Self-perceived health (a 5 point scale) 2. Perceived quality of life (a 7 point scale) 3. Health-related quality of life (EQ-5D – Euro-QoL) 4. Social care outcomes (ASCOT – Adult Social Care Outcomes Toolkit). However, note that contamination is clearly possible in 1 of the reablement groups, which is a service where the same care workers provide both standard home care and reablement.</p> <p><b>In the groups being compared (exposed versus</b></p>	<p>care.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. Home setting.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. Reablement home care.</p> <p><b>Are the study outcomes relevant to the guideline?</b> Yes.</p> <p><b>Are the views and experiences reported relevant to the guideline?</b> Yes.</p> <p><b>Does the study have a UK perspective?</b> Yes. Nine local councils in the UK (Brighton and Hove, London Borough of Croydon, Hampshire County Council, Haringey Council, Leicestershire County Council, Lincolnshire</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>and verifying. It was summarised into interview summaries and thematic summaries according to analytical categories generated by the researcher, based on iterative reading. According to the authors, this process meant interview themes could be examined in their entirety and contradictions between user and carer accounts could be identified. Conclusions were drawn and verified through checking transcripts and through discussion with the other researchers.</p> <p><b>Is appropriate consideration given to how findings relate to the context, such as the setting, in which the data were collected?</b> Partly. The authors note that since the interviews with service users were conducted separately from the comparative study or observations, reablement practice may have developed by the time the interviews took</p>	<p><b>non-exposed; with intervention versus without; cases versus controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?</b> Partly. Both groups generally comparable in demographics. However, service users in the comparison group were statistically significantly more likely to have been classified as having critical or substantial levels of need than those in the reablement group (Table 3.4). It casts doubt on the comparison group's ability to act as a control in relation to improved social care outcomes and perceived health related quality of life. However, acknowledging the important baseline differences in Fair Access to Care Services and activities of daily living dependency, the researchers conducted analyses which adjusted for them (after which</p>	<p>Council, North East Lincolnshire Council, Nottinghamshire County Council and Wirral Borough Council).</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>place. The authors fail to acknowledge that since the interviews were conducted towards the end of the reablement service, while still receiving the intervention, people's views would not include or be influenced by the often difficult process of transfer to an ongoing home care provider.</p> <p><b>Is appropriate consideration given to how findings relate to researchers' influence; for example, though their interactions with participants?</b> Unclear. There is no discussion about this aspect - just a reference made to how the researchers tried to reduce the influence of carers being present during some of the interviews with people using reablement.</p> <p><b>Qualitative component:</b> Collection and analysis of qualitative data relating to the organisation and delivery of</p>	<p>a significant positive effect of reablement still seems to be supported).</p> <p><b>Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?</b> No. Huge numbers were lost to follow up in terms of outcome data (cost data will be reviewed separately) 1,015 people were recruited at baseline (654 reablement home care group and 361 conventional home care group). At 9 to 12 months, 633 participants (62%) were lost to the study because of death, illness, (re)hospitalisation or refusal to participate in the follow-up interview. The number of people who completed follow-up at 12 months was 241 (out of 654) in the reablement group and 141</p>		

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>home care reablement - Interviews with service managers; observation visits with a sample of people using reablement; focus groups with front line reablement staff.</p> <p><b>Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question?</b> Yes. The rationale for the selection of respondents for the manager interviews is clear and seems to represent all the reablement sites. The selection of cases for the observation work also seems appropriate and the focus of the observations seems relevant. However only 26 observation visits were made for the whole study, so approximately 5 per site. Finally, 1 focus group with front line workers was conducted in each site. There is no information about how staff were selected for participation in the focus groups, which may or may not</p>	<p>(out of 361) in the comparison group. So, excluding those who died, 53% from the reablement group were lost at follow-up and 49% in the comparison (the difference between the 2 is not significant). This casts doubt on the outcome data. Also the follow up was 9 to 12 months after intervention, which may be regarded as medium term rather than long term outcomes.</p> <p><b>Is the mixed-methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed-methods question?</b> Yes.</p> <p><b>Is the integration of qualitative and quantitative data (or results) relevant to address the research question?</b> Partly. The</p>		

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>have led to the introduction of bias. Using the 3 methodologies provided the opportunity to gather rich data and to triangulate findings.</p> <p><b>Is the process for analysing qualitative data relevant to address the research question?</b> Yes. Observation visits were analysed using the framework approach and by a process of data reduction, data display, and conclusion drawing and verifying through discussions with the research team and recourse to the transcripts.</p> <p><b>Is appropriate consideration given to how findings relate to the context, such as the setting, in which the data were collected?</b> No. There is no discussion about the different contexts (e.g. different reablement services) in which the interviews/ focus groups or observations were conducted.</p>	<p>combination of qualitative and quantitative (including cost) data provided rich data (including that which is reported elsewhere). However the study would have benefited from conducting face to face interviews with people who were part of the comparative study in order to link qualitative and quantitative data.</p> <p><b>Is appropriate consideration given to the limitations associated with this integration, such as the divergence of qualitative and quantitative data (or results)?</b> Unclear. This is not discussed by the authors.</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Is appropriate consideration given to how findings relate to researchers' influence; for example, though their interactions with participants?</b> No. This is not discussed and is particularly surprising in the case of the observation visits where the presence of the researcher was very likely to affect the behaviour of the person using reablement and the reablement worker.</p>			

**3. Lewin G, Allan J, Patterson C et al. (2014) A comparison of the home-care and healthcare service use and costs of older Australians randomised to receive a restorative or a conventional homecare service. Health and Social Care in the Community 22: 328–36**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> The study aimed to compare ‘... the health and aged care service use and costs of older home-care clients who were randomly assigned to receive either a restorative or conventional home-care service’ (p329).</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Yes. The intervention does not appear to have been altered in anyway once the trial had begun although it appears that there were 45 participants who received less than 3 hours of either comparison or</p>	<p><b>Does the study’s research question match the review question?</b> Yes. The study aimed to compare ‘... the health and aged care service use and costs of older home-care clients who were randomly assigned to receive either a restorative or conventional home-care</p>	<p><b>Overall assessment of internal validity:</b> - A key limitation of the study is the possibility that the randomisation process may have been compromised and it is therefore difficult to apply a higher quality rating.</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Methodology:</b> Randomised controlled trial.</p> <p><b>Description of theoretical approach?</b> No. The authors do not describe their theoretical approach or present a logic model, instead simply hypothesising that the intervention will reduce the need for home care services, reduce the likelihood of use of residential aged care, reduce the number of presentations to emergency departments as well as the number of unplanned hospital admissions, and reduce costs to the aged and health care sectors.</p> <p><b>How was selection bias minimised?</b> Randomised. Randomisation by computer algorithm.</p> <p><b>Was the allocation method concealed?</b> No. It appears that some staff were able to circumnavigate the randomisation process and</p>	<p>intervention treatment. The authors report that these participants were excluded from the as treated analysis.</p> <p><b>Was contamination acceptably low?</b> Yes. There is no indication that any participants received interventions to which they were not allocated.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> No. There is no indication that either group received extra services or received them in a different manner however analysis of baseline differences showed that participants in the control group were significantly more likely to have been in receipt of a personal care service during the previous year (p=0.02).</p> <p><b>Were outcomes relevant?</b> Yes. The study aimed to examine the impact of the</p>	<p>service' (p329). The authors note that the service is usually described as home care reablement in the United Kingdom and the intervention appears to meet the definition of reablement outlined in the 2015 National Audit of Intermediate Care.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Partly. The study was approved by the Western Australian Department of Health and the care providers own research ethics committee however the study does not report details in relation to participant consent.</p> <p><b>Were service users involved in the design of the study?</b> No. Service users involved as participants only. There is no indication that service users were involved in the design of the study or interpretation of the findings.</p>	<p><b>Overall assessment of external validity:</b> ++</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>assign participants to the group which they felt most appropriate.</p> <p><b>Were participants blinded?</b> Blinding not possible. Due to the nature of the intervention it would not have been possible to blind participants to group allocation.</p> <p><b>Were providers blinded?</b> Blinding not possible. Due to the nature of the intervention it would not have been possible to blind providers to group allocation.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Not reported. The authors do not discuss blinding of outcome assessors.</p> <p><b>Did participants represent the target group?</b> Partly. The study does not report the proportion of eligible individuals who agreed to participate however the trials inclusion/exclusion criteria appear appropriate.</p>	<p>intervention on health and aged care use and costs. These data were collated from service records.</p> <p><b>Were outcome measures reliable?</b> Yes. Data were collected using national databases of service use. However it should be noted that some data were only available in calendar quarters rather than financial years and the authors report that this may have resulted in an over or under estimation of the number of service hours used by each participant or the results of aged care assessments for each year of the follow-up period. It is suggested however that this '...measurement bias was non-differential and, if present, would have weakened the measure of association towards the null' (p335).</p> <p><b>Were all outcome measurements complete?</b> Yes. All data appear to have</p>	<p><b>Is there a clear focus on the guideline topic?</b> Yes. The study evaluates a restorative home care service that appears to meet the definition of reablement outlined in the 2015 National Audit of Intermediate Care.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. All participants were over the age of 18 however it should be noted that the study's inclusion criteria specified an age of at least 65 years.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. Interventions and assessments were conducted in the homes of participants.</p> <p><b>Does the study relate to at least one of the activities</b></p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Were all participants accounted for at study conclusion?</b> Not reported. The number of participants lost to follow-up is not reported by the authors. These data are available in Lewin G et al. (2013).</p>	<p>been collected and reported as intended.</p> <p><b>Were all important outcomes assessed?</b> Yes.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. Both groups were followed up for the same length of time.</p> <p><b>Was follow-up time meaningful?</b> Yes. The follow-up period was 2 years although it is not clear whether the follow-up period was measured from referral, randomisation, etc.</p> <p><b>Were the analytical methods appropriate?</b> Yes. Analysis included use of t-tests, chi-square tests, logistic regression, etc.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> No. Analysis</p>	<p><b>covered by the guideline?</b> Yes. Restorative care is considered to be equivalent to reablement.</p> <p><b>Are the study outcomes relevant to the guideline?</b> Yes. The study measured use of care and service costs.</p> <p><b>Was the study conducted in the UK?</b> No. The study was conducted in Australia.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>on the basis of intention to treat showed that participants in the intervention group were significantly less likely to have a carer (p=0.004); significantly more likely to live alone (p=0.016), and to have significantly higher scores (i.e. to be more independent) on the care provider's Activities of Daily Living (p=0.013) and Instrumental Activities of Daily Living (p&lt;0.001) scales. This analysis also showed that participants in the control group were significantly more likely to have been in receipt of a personal care service during the previous year (p=0.02) although the authors suggest that these participants '... represented a very small proportion of the group as a whole' (p331).</p> <p>Analysis on the basis of care received showed that participants in the intervention group were still significantly less likely to have a carer</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>(p=0.004); and to have significantly higher scores on scales of Activities of Daily Living (p=0.005) and Instrumental Activities of Daily Living (p&lt;0.001). This analysis also showed that participants in the intervention group were significantly more likely to be female (p=0.025); significantly more likely to live alone (p=0.005); and significantly less likely to have a co-resident carer (p=0.014). Participants in the control group were still significantly more likely to have been in receipt of a personal care service during the previous year (p=0.001).</p> <p>These differences were not adjusted for in all analyses of between group differences (i.e. use of aged care and health care).</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Partly. The authors state that data</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>were analysed on both an intent to treat and an as treated basis.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Yes. Although the authors do not present a power calculation they report that the trial had 79% power.</p> <p><b>Were the estimates of effect size given or calculable?</b> Yes. Odds and risk ratios are provided with 95% confidence intervals.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Yes. p values are reported.</p> <p><b>Do conclusions match findings?</b> Partly. The conclusion tends to rely on data from the as treated rather than intention-to-treat analysis.</p>		

**4. Lewin G, De San Miguel K, Knuiman M et al. (2013) A randomised controlled trial of the Home Independence Program, an Australian restorative home-care programme for older adults. Health and Social Care in the Community 21: 69-78**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To ‘... test the effectiveness of the Home Independence Program (HIP), a restorative home care programme for adults ...’ (p69).</p> <p><b>Methodology:</b> Randomised controlled trial.</p> <p><b>Description of theoretical approach?</b> Partly. The authors do not present a theory of change or logic model, they simply hypothesise that the intervention will reduce the need for ongoing personal care services. However, the authors describe the intervention as a ‘new paradigm’.</p> <p><b>How was selection bias minimised?</b> Randomised. The providers referral handling programme appears to have been modified to allocate eligible individuals ‘... to either the intervention or control group based on alternating tenths of a</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Yes. The interventions do not appear to have been modified once participants had begun to receive care however it should be noted that 45 participants did not receive ‘sufficient service’ (three hours of personal care for the control group and 3 visits for the intervention group). These participants were included in the intention to treat analysis but excluded from the as-treated analysis.</p> <p><b>Was contamination acceptably low?</b> Not reported. The researchers had agreed in advance that if participants who had been randomised to the intervention group were (after 2 weeks) not participating for ‘any reason’ they would be reassigned to the control group (p72). The</p>	<p><b>Does the study’s research question match the review question?</b> Yes. The study aimed to ‘... test the effectiveness of the Home Independence Program (HIP), a restorative home care programme for adults ...’ (p69). Restorative home care is a term used in Australia and denotes an intervention with similar features to those interventions described as reablement in the United Kingdom. The intervention also appears to meet the definition of reablement used in the 2015 National Audit of Intermediate Care.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Partly. Although a research ethics committee approved the study this appears to be a committee based within a private care company rather</p>	<p><b>Overall assessment of internal validity:</b> -</p> <p>The possibility that operators may have been able to circumvent the randomisation process, the apparently high numbers of eligible individuals who did not take part, the decision to only measure function and quality of life related outcomes for a subgroup of participants (and the method by which participants were recruited to subgroups), and the use of modified activities and instrumental activities of daily living scales suggest that the results of this trial should be interpreted with caution.</p> <p><b>Overall assessment of external validity:</b> ++</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>second' (p71). However, it appears that operators were able to circumvent this process. The study also measured functional ability and quality of life related outcomes for a subgroup of participants. Recruitment to these subgroups does not appear to have been randomised as recruitment was restricted to a maximum of 4 intervention and 4 control subjects each week however the groups were calculated to be representative. A research assistant (blinded) was instructed which participants to contact to take part in this subgroup and this process continued until each group included the target number of 150 participants.</p> <p><b>Was the allocation method concealed?</b> No. Operators were able to circumvent the process and assign participants to either the control or the intervention group according to their belief regarding which</p>	<p>number of participants for whom this was the case is not reported. In addition, the authors note in their discussion that the control group could have been contaminated by '... an increased emphasis on independence across the home-care agency ...' (p69).</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> Partly. The researchers recorded/measured the receipt of other community services over the course of the trial however they do not report whether there were statistically significant between group differences in relation to this.</p> <p><b>Were outcomes relevant?</b> Yes. The study's primary outcome was use of personal care and this was measured directly using service data.</p>	<p>than an academic or regional/local authority based body. In addition, it appears that participants were only asked for formal consent after they had been randomised and had begun to receive their allocated intervention.</p> <p><b>Were service users involved in the design of the study?</b> No. Service users involved as participants only. There is no indication that service users were involved in the design of the study or interpretation of the findings.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study evaluates a restorative home care service that appears to meet the definition of reablement outlined in the 2015 National Audit of Intermediate Care.</p> <p><b>Is the study population the same as at least one of the groups covered by the</b></p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>would be most beneficial for that individual.</p> <p><b>Were participants blinded?</b> Blinding not possible. Due to the nature of the intervention it would not have been possible to blind participants to group allocation.</p> <p><b>Were providers blinded?</b> Blinding not possible. Due to the nature of the intervention it would not have been possible to blind providers to group allocation.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Not blind. It appears that participants often revealed group allocation to research assistants during the course of their outcome assessments. It is not clear whether researchers collating service level data were blinded to group allocation.</p> <p><b>Did participants represent the target group?</b> No. The authors</p>	<p><b>Were outcome measures reliable?</b> Partly. Service data were collected from a number of databases and the authors do not discuss the issue of missing data. This information was used to establish important demographic information which was then used to control for in results of the data analysis. Functional ability and quality of life appear to have been assessed using the Primary Assessment Form; a tool developed by care providers. This includes an Activities of Daily Living scale (based on the Modified Barthel Index, Colin et al. 1988) and an Instrumental Activities of Daily Living (based on the Brody Scale, Lawton and Brody, 1969). The latter appears to have been modified to enable scoring to increase in relation to the assistance participants need for each task. Although these scales appear to have established reliability and validity their</p>	<p><b>guideline?</b> Yes. All participants were over the age of 18 however it should be noted that the trial's inclusion criteria specified an age of at least 65 years.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. Interventions and assessments were conducted in the homes of participants.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. Restorative home care is considered to be equivalent to reablement.</p> <p><b>Are the study outcomes relevant to the guideline?</b> Yes. The study's primary outcome is need for personal care services. Secondary outcomes relate to functional ability and quality of life.</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>do not report the number of eligible individuals who agreed to participate and it appears that high numbers of individuals could not take part because of service availability in their area. In the participant flow diagram the authors report this figure as 532, however the narrative suggests that this number also included individuals who were not randomised because the target sample for a group had been achieved. Due to the problems with service availability the sample size was recalculated so that each of the main groups was comprised of n=375 participants.</p> <p><b>Were all participants accounted for at study conclusion?</b> Not reported. The number of participants lost to follow up appears to be acceptable (approximately 14%) and this appears to be comparable by group however these figures may also include participants who developed a</p>	<p>incorporation into the Primary Assessment Form and the reliability and validity of this format is not established.</p> <p>Mobility, fear of falling and quality of life were assessed using measures that appear to have established reliability and validity however data to support this are not presented.</p> <p><b>Were all outcome measurements complete?</b> All data appears to have been collected and reported as planned but functional and quality of life outcomes were only assessed for a subgroup of participants and data for this subgroup are not reported in full (the authors simply state in their narrative that no between group differences were found. In addition, some participants in the subgroup had already begun to receive care as allocated before baseline assessments of functional ability and quality of life were</p>	<p><b>Was the study conducted in the UK?</b> No. The study was conducted in Australia.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>terminal illness and were therefore excluded from the analysis. The reasons for loss to follow-up are recorded. A number of participants declined to participate further and others were unreachable.</p>	<p>conducted. The authors therefore incorporated data from the provider's telephone referral assessments as baseline data. There are no details provided on procedures for missing data, a significant omission.</p> <p><b>Were all important outcomes assessed?</b> Yes. Although it is disappointing that the effects of the interventions on carers were not assessed.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. Both groups were followed up for the same length of time.</p> <p><b>Was follow-up time meaningful?</b> Partly. Follow-up assessments took place at 3 months and 12 months, although it is not clear whether this was post-referral, post-randomisation, etc. and the rationale for these follow-up points is unclear.</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Were the analytical methods appropriate?</b> Yes. Logistic regression and linear regression as well as t-tests and chi-square tests.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> No. At baseline there were a number of differences between the 2 groups. The intervention group was statistically significantly less likely to have a carer (in both intent to treat analysis and as treated analysis, both <math>p=0.004</math>) and more likely to live alone (intent to treat analysis <math>p=0.016</math>; <math>p=0.005</math> and as treated analysis). There was also a statistically significant difference between groups in relation to gender when as treated analysis was conducted, with a higher proportion of females in the intervention group than in the control group (<math>p=0.025</math>). The</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>authors also report narratively that there was a statistically significant (but clinically insignificant) difference between the 2 groups in level of dependency measured using the Home and Community Care programme Needs Identification scale. However, it appears that this measure is actually a combination of the Activities of Daily Living and the Instrumental Activities of Daily Living scales, and there were significant differences between groups on both of these. The intervention group had better scores on the Activities of Daily Living scale when both intent to treat and as treated analysis were conducted (<math>p=0.013</math>; <math>p=0.005</math>) and on the Instrumental Activities of Daily Living scale when both intent to treat and as treated analysis were conducted (<math>p&lt;0.001</math>; <math>p&lt;0.001</math>).</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>The study only measured functional outcomes for a subgroup of participants and the authors report that there were also differences between subgroup participants in relation to treatment group when as-treated analysis was conducted (for whom there was complete follow-up data). Subgroup participants randomised to the intervention group were statistically significantly more likely to live alone (<math>\chi^2[1, n=192]=4.212, p=0.04</math>) and less likely to have a carer (<math>\chi^2[1, n=106]=4.499, p=0.03</math>).</p> <p>The authors state that these differences were adjusted for in the analyses but do not report how this was done.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Yes. The authors report the results of intention to treat and as treated analyses however it appears that some participants</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>were excluded from certain analyses that are reported as intention to treat.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Yes. Although the authors do not present a power calculation, they report that the study overall had 90% statistical power to detect a difference of 12% in service outcomes at a significance level of 5%. For the subgroup analysis, the study had 90% statistical power to detect a difference of 0.4 SD in functional outcomes at a significance level of 5%.</p> <p><b>Were the estimates of effect size given or calculable?</b> Yes. Odds ratios are provided.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Partly. p values are provided for some data.</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	Do conclusions match findings? Yes.		

**5. Lewin G and Vandermeulen S (2010) A non-randomised controlled trial of the Home Independence Program (HIP): An Australian restorative programme for older home-care clients. Health and Social Care in the Community 18: 91–9**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To test the ‘... hypothesis that individuals referred for home care who participated in a restorative programme would have better personal (functional gain and improved well-being) and service (need for ongoing home care) outcomes than individuals who only received ‘usual’ home care’ (p92).</p> <p><b>Methodology:</b> Comparison evaluation. Controlled trial.</p> <p><b>Description of theoretical approach?</b> No. The authors do not outline the theoretical basis of the intervention.</p> <p><b>How was selection bias minimised?</b> Unmatched</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Yes. There is no indication that the intervention or control treatments were modified after the trial had begun.</p> <p><b>Was contamination acceptably low?</b> Yes. There is no indication that participants in the intervention group received the control treatment or vice versa.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> No. There is no indication that either group received additional services or had care provided</p>	<p><b>Does the study’s research question match the review question?</b> Yes. The researchers aimed to test the ‘... hypothesis that individuals referred for home care who participated in a restorative programme would have better personal (functional gain and improved well-being) and service (need for ongoing home care) outcomes than individuals who only received ‘usual’ home care’ (p92).</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. A university based research ethics committee approved</p>	<p><b>Overall assessment of internal validity:</b> -</p> <p><b>Overall assessment of external validity:</b> ++</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>groups. The study reports the results of a controlled trial and baseline comparisons showed that there were a number of differences between groups. The authors note that it was not possible to conduct a randomised controlled trial as '... the operational trial had been implemented such that individuals living in the areas where the trial was being run were either directly referred to HIP or had chosen at referral to participate in the new programme. The control group therefore included clients living in suburbs outside the catchment area for the operational trial, who were similar to clients in the intervention group in terms of commencing services in the same week and meeting the study inclusion criteria' (p92). Recruitment was conducted on a weekly basis, with those referred to the Home Independence Programme being contacted by phone to ask</p>	<p>in a different manner.</p> <p><b>Were outcomes relevant?</b> Partly. The study aimed to examine the effect of the intervention on service user outcomes such as confidence in everyday activities, functional dependency, functional mobility, morale, etc. as well as service outcomes and these were measured directly.</p> <p><b>Were outcome measures reliable?</b> Partly. Although the majority of outcome measures appear to have established reliability and validity, data to support this are not presented. In addition, it is not clear why the study used the provider developed Primary Assessment Form (based on the Modified Barthel Index and the Lawton and Brody scale) to measure activities and instrumental activities of daily living. It should also be noted that service data were</p>	<p>the study and written consent was sought from participants.</p> <p><b>Were service users involved in the design of the study?</b> No. Service users involved as participants only. There is no indication that service users were involved in the design of the study or interpretation of the findings.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study reports on an evaluation of a short-term restorative programme of care that appears to meet the definition of reablement outlined in the 2015 National Audit of Intermediate Care.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. All participants were over the age of 18 however it should be noted that the intervention is targeted at older home</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>if they were willing to participate in the study. After these participants had consented, the researchers then tried to recruit an equal number of 'controls'.</p> <p><b>Was the allocation method concealed?</b> N/A.</p> <p><b>Were participants blinded?</b> Blinding not possible. Due to the nature of the intervention it would not have been possible to blind participants to group allocation.</p> <p><b>Were providers blinded?</b> Blinding not possible. Due to the nature of the intervention it would not have been possible to blind providers to group allocation.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Not blind. Research assistants who conducted outcome assessments were not blinded. The authors' narrative reports that these individuals</p>	<p>collected using the providers own database rather than national/official sources.</p> <p><b>Were all outcome measurements complete?</b> Yes. All data appears to have been collected and reported as planned however there were some participants who did not complete the Timed Up and Go test at baseline.</p> <p><b>Were all important outcomes assessed?</b> Partly. The study did not measure the impact of the intervention on informal/unpaid care, use of other care services (e.g. presentation at accident and emergency department), and it seems disappointing that only the Modified Falls Efficacy Scale was used in relation to falls as this only measures confidence rather than number of falls.</p> <p><b>Were there similar follow-up times in exposure and</b></p>	<p>care service users and the authors report that participants were over the age of 60. The mean age of the intervention group at baseline was 79.6 years and the mean age of the control group at baseline was 79.8 years.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. Interventions and assessments were conducted in the homes of participants.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. The restorative programme is considered to be equivalent to reablement.</p> <p><b>Are the study outcomes relevant to the guideline?</b> Yes. The study reports on service user outcomes such as confidence in everyday</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>were members of staff from the home care provider who ‘... could not be blinded to whether the individual was in the intervention or the control group as it was common knowledge throughout the organisation which service centre was running the HIP operational trial’ (p94).</p> <p><b>Did participants represent the target group?</b> Not clear. The study does not clearly report the number of eligible individuals who agreed to participate. Although the authors report that 131 participants receiving the intervention were asked to participate (100 agreed) and 147 participants receiving the control intervention were asked to participate (100 agreed) it is not clear how the sample for this study relates to the wider population of participants receiving the 2 services. In addition, it is not clear what the eligibility criteria for the services are or what the</p>	<p><b>comparison groups?</b> Yes. Both groups were followed-up for the same length of time.</p> <p><b>Was follow-up time meaningful?</b> Yes. Final follow-up assessments were conducted at 12 months which would allow both short-term and intermediate-term effects of the intervention to be detected.</p> <p><b>Were the analytical methods appropriate?</b> Yes. Analyses included Mann–Whitney U-tests, linear regression and logistic regression.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> No. Baseline comparisons showed that there were a number of differences between groups. The authors report that participants in the intervention group were less likely to live alone (although it is not clear if</p>	<p>activities, functional dependency, functional mobility, morale, etc., as well as service outcomes.</p> <p><b>Was the study conducted in the UK?</b> No. The study was conducted in Australia.</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>inclusion/exclusion criteria for the trial were and these appear to be conflated by the authors.</p> <p><b>Were all participants accounted for at study conclusion?</b> Partly. Although loss to follow up appears to be comparable by group and the reasons for these losses are reported, by the 12 month assessment point 30% of participants had been lost to follow-up.</p>	<p>this difference was statistically significant), and significantly more likely to have a carer (p=0.044) than those in the control group. At baseline, participants in the intervention group were also more dependent in activities of daily living (p&lt;0.01) and instrumental activities of daily living (p&lt;0.01) both measured using the Primary Assessment Form; and had slower times on the Timed Up and Go test (p&lt;0.01), and poorer scores on the Philadelphia Geriatric Morale Scale (p&lt;0.01). It is not clear whether these differences were adjusted for in all analyses.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Not reported.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Yes. Although power calculations are not presented,</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>the authors determined that a sample size of 96 was needed to detect differences at 80% power and a significance level of 0.05. The number of participants in each group who consented and took part in baseline assessments was 100.</p> <p><b>Were the estimates of effect size given or calculable?</b> Yes.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Yes. p values and 95% confidence intervals are reported where appropriate.</p> <p><b>Do conclusions match findings?</b> Yes.</p>		

**6. Tinetti ME, Charpentier P, Gottschalk M et al. (2012) Effect of a Restorative Model of Posthospital Home Care on Hospital Readmissions. Journal of the American Geriatrics Society 60: 1521-6**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To compare readmissions of Medicare recipients of usual home care and a matched group of recipients of a restorative model of home care.</p> <p><b>Methodology:</b> Comparison evaluation. Quasi-experimental evaluation.</p> <p><b>Description of theoretical approach?</b> Yes. The basis for the study is the need to reduce healthcare costs incurred through readmissions to hospital. Older age is cited as 1 of the factors associated with readmissions. Many older adults with chronic conditions and functional limitations receive home care from a Medicare-qualified home care agency after an acute hospital stay. Since there is a link between functional dependence and readmissions, the authors suggest that enhancing physical</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Yes. No attempt was made to change the home care practice.</p> <p><b>Was contamination acceptably low?</b> Yes.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> No.</p> <p><b>Were outcomes relevant?</b> Yes.</p> <p><b>Were outcome measures reliable?</b> Yes. Results of the OASIS (Outcome and Assessment Information Set) were dichotomized as remaining at home or readmission to an acute hospital.</p>	<p><b>Does the study's research question match the review question?</b> Yes. Matches both our intervention (restorative care) and our outcomes (readmissions and length of care episode).</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Partly. The Yale School of Medicine human investigations committee approved the study. However, there is no evidence that participants gave their consent to be involved in the study and given that 1 group received restorative care and the other received usual care this seems ethically questionable.</p> <p><b>Were service users involved in the design of the study?</b> No.</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>recovery during receipt of home care could reduce the risk of hospital readmissions. Restorative home care offers this support with functional recovery hence the theory that the intervention will reduce hospital readmissions.</p> <p><b>How was selection bias minimised?</b> Quasi-experimental. Allocation was not randomised although risk of bias minimised through prospective matching.</p> <p><b>Was the allocation method concealed?</b> Yes. Matched via a computerised algorithm.</p> <p><b>Were participants blinded?</b> Not reported. Blinding to the 2 groups was not reported. However, it also appears that participants were blinded to their participation in the study as a whole.</p> <p><b>Were providers blinded?</b> Not blind.</p>	<p><b>Were all outcome measurements complete?</b> Yes.</p> <p><b>Were all important outcomes assessed?</b> Partly. Only service outcomes are measured. No service user or carer outcomes were included so we have no idea about the effect of the intervention on people's wellbeing. Also, the authors did not investigate service user views or experiences so we do not know about the acceptability or accessibility of the service.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes.</p> <p><b>Was follow-up time meaningful?</b> No. Follow up isn't clearly described. It appears that outcomes were measured at the end of the home care episode rather than at any fixed point. The study would</p>	<p><b>Is there a clear focus on the guideline topic?</b> Yes. Intervention and outcomes are within the scope of the guideline topic.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. Although people under 65 years were excluded.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. Peoples own homes.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. Restorative care.</p> <p><b>Are the study outcomes relevant to the guideline?</b> Yes.</p> <p><b>Was the study conducted in the UK?</b> No. The study</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Not blind.</p> <p><b>Did participants represent the target group?</b> Partly. People with severe cognitive impairment (that would impede ability to participate) were excluded as were people requiring total assistance with care.</p> <p><b>Were all participants accounted for at study conclusion?</b> Yes.</p>	<p>have benefitted from follow up at a later stage to assess outcomes in the medium to long term.</p> <p><b>Were the analytical methods appropriate?</b> Yes. Analysis of data is appropriate. Participants were matched using a computerized algorithm and any differences between the matched restorative and usual care groups were assessed using the McNemar test for binary variables and the paired t-test for continuous variables. In addition logistic regression, using the entire sample, was used to test the robustness of the matched results. In this confirmatory unmatched analysis, demographic, medical, and functional factors that may confound the relationship between the restorative effect and readmissions were controlled for.</p>	<p>was conducted in the United States.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Yes. The majority of the participants were matched and for those (88) that weren't, results were adjusted.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Not reported.</p> <p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Not reported.</p> <p><b>Were the estimates of effect size given or calculable?</b> Yes. Odds ratios are presented.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Yes. p values and confidence intervals are provided.</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	Do conclusions match findings? Yes.		

7. Tuntland H, Aaslund MK, Espehaug B et al. (2015) Reablement in community-dwelling older adults: A randomised controlled trial. *BMC Geriatrics* 15: 145

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> The authors aimed to ‘... evaluate whether reablement is more effective with regard to self-perceived activity performance and satisfaction with performance, physical functioning, and health-related quality of life compared with usual care’ (p2).</p> <p><b>Methodology:</b> Randomised controlled trial.</p> <p><b>Description of theoretical approach?</b> No. The authors do not describe the rationale underpinning the intervention.</p> <p><b>How was selection bias minimised?</b> Randomised. Computerised permuted block randomisation sequence (randomly selected block sizes</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Yes. There is no indication that care provided to those in the intervention or comparison group was altered once the trial had begun. It does however appear that there were recruitment problems and the authors narrative suggests that the intervention was therefore implemented in districts in which this was not originally planned.</p> <p><b>Was contamination acceptably low?</b> Yes. There is no indication that any participants in the control group received the intervention or vice versa. The authors do report that there may have</p>	<p><b>Does the study’s research question match the review question?</b> Yes. The authors aimed to ‘... evaluate whether reablement is more effective with regard to self-perceived activity performance and satisfaction with performance, physical functioning, and health-related quality of life compared with usual care’ (p2).</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. A research ethics committee approved the study and participants provided written consent.</p> <p><b>Were service users involved in the design of</b></p>	<p><b>Overall assessment of internal validity:</b> ++</p> <p><b>Overall assessment of external validity:</b> ++</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>of 2 and 4) and an allocation ratio of 1:1.</p> <p><b>Was the allocation method concealed?</b> Yes. Allocation was concealed using sealed opaque envelopes.</p> <p><b>Were participants blinded?</b> Blinding not possible. Due to the nature of the intervention it would not have been possible to blind participants to group allocation.</p> <p><b>Were providers blinded?</b> Blinding not possible. Due to the nature of the intervention it would not have been possible to blind providers to group allocation.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> Part blind. Although the research assistants who conducted follow-up assessments were originally blinded to group allocation it appears that participants may</p>	<p>been contamination due to the same practitioners delivering both the intervention and the control to different participants however this is unlikely to have had a significant impact.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> Partly. Both groups received home based care from a range of practitioners with nurses and auxiliary nurses being the most frequent provider of care for either group. The authors report that there was a higher emphasis on rehabilitation in the intervention group with more visits being made by therapists. In contrast, the authors also report narratively that at 3 month follow-up there was a significantly higher number of co-interventions in the control group and that ‘...12 outpatient treatments in the control group versus 3 outpatient treatments in the</p>	<p><b>the study?</b> No. Service users involved as participants only. There is no indication that service users were involved in the design of the study or interpretation of the findings.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study focuses on an intervention described as reablement that appears to meet the definition used in the 2015 National Audit of Intermediate Care.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. All participants were over the age of 18 however it should be noted that although the authors did not exclude younger adults the mean age of the intervention group was 79.9 years and the mean age of the control group was 78.1 years.</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>have revealed this information. The authors report a success rate in relation to blinding of research assistants of 63% at the 3 month assessment and 64% at the 9 month assessment.</p> <p><b>Did participants represent the target group?</b> Yes. An acceptable number of eligible individuals agreed to participate (over 80%).</p> <p><b>Were all participants accounted for at study conclusion?</b> Yes. The number of participants lost to follow-up was acceptable and appears to be comparable by group.</p>	<p>intervention group (p=0.007), of which 10 of the outpatient treatments were physiotherapy ...' (p4), however it is unclear what exactly the differences between groups were.</p> <p><b>Were outcomes relevant?</b> Yes. The authors aimed to evaluate the effect of reablement on daily activity, health-related quality of life, and physical functioning. These were assessed using suitable measures.</p> <p><b>Were outcome measures reliable?</b> Partly. Although all outcome measures appear to have established reliability and validity data to support this are not presented. In addition, it should be noted that although the study's primary outcome related to performance of everyday activities this was a measure of service user self-perception rather than an observable and objective measure.</p>	<p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. The interventions and assessments were conducted in participant's homes.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. The study evaluates the impact of a reablement service.</p> <p><b>Are the study outcomes relevant to the guideline?</b> Yes. The study measured self-perceived performance of activities, functional mobility, grip strength and health related quality of life.</p> <p><b>Was the study conducted in the UK?</b> No. The study was conducted in Norway.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Were all outcome measurements complete?</b> Yes. All data appear to have been collected and reported on as planned.</p> <p><b>Were all important outcomes assessed?</b> Partly. It is disappointing that an observable measure of ability in relation to daily living was not used in the study.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> Yes. Both groups were followed up for the same amount of time.</p> <p><b>Was follow-up time meaningful?</b> Partly. The final follow-up assessment took place at 9 months, which is unlikely to have been sufficient to allow medium or long-term effects to be detected. It is not clear whether the follow-up period was measured from referral, randomisation, etc.</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Were the analytical methods appropriate?</b> Yes. Mixed effect models.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> Yes. There were no significant differences between groups at baseline in relation to demographics or outcome measures. Although there were no significant differences at baseline the researchers adjusted for potential baseline differences by subtracting baseline effect sizes from follow-up effect sizes. It is not clear why this was done.</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Partly. The authors report that intention-to-treat analysis however participants who were lost to follow-up appear to have been excluded from analyses.</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Yes. The authors estimated that we estimated that 42 participants were required in order to detect an effect at 80 % power. This target was increased to 60 to allow for a 40% rate and 61 participants were randomised.</p> <p><b>Were the estimates of effect size given or calculable?</b> Yes. Effect sizes using Cohen's d are provided.</p> <p><b>Was the precision of intervention effects given or calculable?</b> Were they meaningful? Yes. 95% confidence intervals and p values are reported.</p> <p><b>Do conclusions match findings?</b> Yes.</p>		

## Review question 4 – Critical appraisal – the views and experiences of people using services, their families and carers

### 1. Ariss S (2014) National audit for intermediate care: Patient reported experiences, 2014. Sheffield: University of Sheffield

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To obtain views and experiences from people using intermediate care (reablement) by asking the following survey question, ‘Do you feel that there is something that could have made your experience of the service better?’ (Pages not numbered, so page numbers of quotes not attributed.)</p> <p><b>Methodology:</b> Survey.</p> <p><b>Objectives of the study clearly stated?</b> Partly. The objective is simply to answer 1 single survey question.</p> <p><b>Research design clearly specified and appropriate?</b> Partly. It is not clear exactly how the survey was conducted although the methods of analysis are described.</p>	<p><b>Describes what was measured, how it was measured and the results?</b> N/A. Nothing was measured as such because the survey only comprised of 1 open ended questions to elicit people's views.</p> <p><b>Measurements valid?</b> N/A.</p> <p><b>Measurements reliable?</b> N/A.</p> <p><b>Measurements reproducible?</b> N/A.</p> <p><b>Basic data adequately described?</b> Partly. More data on the numbers/ proportions making certain responses could have been provided.</p> <p><b>Results presented clearly, objectively and in enough</b></p>	<p><b>Does the study’s research question match the review question?</b> Yes. The survey, which was part of the NAIC 2014 asked the question, ‘do you feel that there is something that could have made your experience of the (intermediate care) service better? Yes or no’ and then a space to provide further detail. The question was asked to people using bed based and home based intermediate care and reablement.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> No. There is no discussion of handling ethical issues or obtaining ethical approval for the survey.</p>	<p><b>Overall assessment of internal validity:</b> -</p> <p><b>Overall assessment of external validity:</b> ++</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Clear description of context?</b> Partly. The context of the survey is clear but we do not know the context of the respondents (except that they've used reablement).</p> <p><b>References made to original work if existing tool used?</b> No.</p> <p><b>Reliability and validity of new tool reported?</b> Unclear. No information about the validity and reliability of the single survey question, why it was chosen or worded the way it was.</p> <p><b>Survey population and sample frame clearly described?</b> Partly. We do not have a description of the sampling frame (total numbers in England using reablement) but the sample is described in the abstract which states that the survey was sent to '250 service-users from 48 reablement services between</p>	<p><b>detail for readers to make personal judgements?</b> Partly.</p> <p><b>Results internally consistent?</b> Partly. On the whole, yes although numbers weren't routinely provided against responses.</p> <p><b>Data suitable for analysis?</b> Yes.</p> <p><b>Clear description of data collection methods and analysis?</b> Partly. Clear description of data analysis but not data collection.</p> <p><b>Methods appropriate for the data?</b> Yes.</p> <p><b>Statistics correctly performed and interpreted?</b> Partly. In terms of statistics, only frequencies were produced and even then, not for all the themes, which means we don't know how many respondents cited each</p>	<p><b>Were service users involved in the study?</b> No.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes.</p> <p><b>Are the views and experiences reported relevant to the guideline?</b> Yes.</p> <p><b>Does the study have a UK perspective?</b> Yes. England only.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>May and August 2013’.</p> <p><b>Representativeness of sample is described?</b> No. We have no idea how representative the sample is.</p> <p><b>Subject of study represents full spectrum of population of interest?</b> Unclear. The author does not provide any information that would help us judge whether the study represents the full spectrum of the population of interest.</p> <p><b>Study large enough to achieve its objectives, sample size estimates performed?</b> No. There is no evidence that sample size estimates have been made.</p> <p><b>All subjects accounted for?</b> No. The paper does not provide a figure for the total number of people who received the survey.</p> <p><b>All appropriate outcomes considered?</b> N/A. No outcomes</p>	<p>issue - this could have been provided in the ranked table. Further statistical analyses could have been usefully produced, e.g. cross tabulations or, if the data had been collected, responses could have been linked with service users’ characteristics.</p> <p><b>Response rate calculation provided?</b> No. Reviewers worked out the response rate.</p> <p><b>Methods for handling missing data described?</b> No.</p> <p><b>Difference between non-respondents and respondents described?</b> No.</p> <p><b>Results discussed in relation to existing knowledge on subject and study objectives?</b> No.</p> <p><b>Limitations of the study stated?</b> No.</p> <p><b>Results can be generalised?</b></p>		

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>were considered. The survey simply comprises of 1 open ended question.</p> <p><b>Response rate:</b> 12,000 reablement users received the survey. Although it is unclear, it appears that responses were received from 1,644 people, giving a response rate of 13.7%.</p>	<p>Partly. Within England probably, although it's hard to tell because the author does not provide any information about the respondents.</p> <p><b>Appropriate attempts made to establish 'reliability' and 'validity' of analysis? No.</b></p> <p><b>Conclusions justified?</b> Unclear. No conclusions are provided in this paper.</p>		

**2. Gethin-Jones S (2013) Focus on the micro-relationship in the delivery of care. British Journal of Healthcare Assistants 7: 452-5**

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p><b>Study aim:</b> The study aimed to find out what older people feel is important in terms of the delivery of their care.</p> <p><b>Methodology:</b> Qualitative.</p> <p><b>Is a qualitative approach appropriate?</b> Appropriate.</p> <p><b>Is the study clear in what it seeks to do?</b> Clear.</p>	<p><b>Is the context clearly described?</b> Clear. The context is the move between reablement and long term home care.</p> <p><b>Was the sampling carried out in an appropriate way?</b> Somewhat appropriate. The sampling wasn't random but this seems to be appropriate because respondents</p>	<p><b>Does the study's research question match the review question?</b> Yes. Views of people who have used reablement.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. Ethical approval was obtained from the ethics committee of Cardiff</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>How defensible/rigorous is the research design/methodology?</b> Somewhat defensible. The sampling was conducted through care managers acting as gatekeepers so they could choose people who had recently used reablement and then moved onto long term home care. This is somewhat defensible although clearly care managers could potentially identify people they knew to have had a particularly positive experience of the reablement service or by contrast who would have something critical to say of the home care service. The approach to interviewing was certainly defensible with the rationale given as '[this] allowed the individuals the chance for self-expression and the ability to expand on the experience of having intimate care delivered in their own home' (p453).</p> <p><b>How well was the data</b></p>	<p>specifically had to have used reablement and be moving to long term home care.</p> <p><b>Were the methods reliable?</b> Somewhat reliable. Only 1 means of data collection was used. No opportunity for triangulation. However the author does discuss his findings alongside other studies.</p> <p><b>Are the data 'rich'?</b> Mixed. Considering interviews were conducted with 30 respondents, the data presented and discussed was not terribly rich. Themes were developed from the responses so we know there is a great deal of consistency but we are given very little information about the contexts of respondents, including where quotes are provided.</p> <p><b>Is the analysis reliable?</b> Somewhat reliable. On the face of it, analysis seems</p>	<p>University and also the relevant local authority's ethics committee, which had oversight of the project. In addition, consent to participate in the study was obtained from all participants during the first of 2 interviews in which interviewers also ensured service users were fully aware of the use of the data.</p> <p><b>Were service users involved in the study?</b> Yes. As participants but not as co-researchers.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. Although everyone had been discharged from hospital - no community referrals.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>collection carried out?</b> Appropriately.</p>	<p>reliable and the author describes the process of identifying themes and then using the themes as categories within which the data were analysed. However, it appears that only 1 researcher was involved in the data collection and analysis so there was no scope for differences in interpretation to be identified and resolved. Furthermore, participants didn't have the opportunity to feedback on transcripts.</p> <p><b>Are the findings convincing?</b> Convincing. Findings are clearly presented and coherent themes are identified. Findings are also supported with quotes from the original data, although more contextual information about the people quoted would have been helpful.</p> <p><b>Are the conclusions adequate?</b> Somewhat adequate. The conclusions are plausible and are supported by</p>	<p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes.</p> <p><b>Are the views and experiences reported relevant to the guideline?</b> Yes.</p> <p><b>Does the study have a UK perspective?</b> Yes.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>the findings. However, they're minimal and don't really reflect the depth of some of the findings and supporting quotes. The conclusions don't add a great deal of understanding to the research topic; not least because they say more about the importance of improving relationships between older people and care workers in long term care. The author does recognise that the study could have been improved by increasing the sample size and ethnic diversity.</p>		

**3. Ghorrae H (2013) Reablement in Glasgow: Quantitative and qualitative research. Glasgow: Glasgow City Council**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> The researchers aimed to explore service user and staff views of a 6 week reablement programme.</p> <p><b>Methodology:</b> Mixed methods.</p> <p><b>Qualitative component:</b> Face to face interviews with service</p>	<p><b>Quantitative component:</b> Survey monkey questionnaire (service users and practitioners).</p> <p><b>Is the sampling strategy relevant to address the quantitative research question (quantitative aspect</b></p>	<p><b>Does the study's research question match the review question?</b> Yes. The researchers aimed to explore service user and staff views of a 6 week reablement programme.</p> <p><b>Has the study dealt</b></p>	<p><b>Overall assessment of internal validity:</b></p> <p>-</p> <p>This is a poor quality study that lacks methodological detail. The research was conducted with a very small group of participants and</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>users and focus groups with practitioners.</p> <p><b>Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question?</b> Partly. Whilst the inclusion of service users with recent experience of the service and practitioners who work as part of or with the team is standard practice there are no details provided in relation to the sampling strategy used to select these participants and no information on the number of individuals who were approached to participate are provided.</p> <p><b>Is the process for analysing qualitative data relevant to address the research question?</b> Unclear. Only minimal detail in relation to the method of data collection is provided and no information is provided at all in relation to data management and data analysis</p>	<p><b>of the mixed-methods question)?</b> Unclear. Whilst the source of both the service user and practitioner samples are clearly relevant no details relating to the sampling strategy are provided.</p> <p><b>Is the sample representative of the population under study?</b> Unclear. No details in relation to inclusion/exclusion criteria are provided and it is not clear how many individuals who were asked to take part did so.</p> <p><b>Are measurements appropriate (clear origin, or validity known, or standard instrument)?</b> N/A. The survey appears to have been designed specifically for this study.</p> <p><b>Is there an acceptable response rate (60% or above)?</b> Unclear. The response rate is not reported.</p>	<p><b>appropriately with any ethical concerns?</b> Partly. Although the study includes an example service user consent form there are no details on consent processes used for staff and there are no details provided regarding ethical approval for the study.</p> <p><b>Were service users involved in the design of the study?</b> No. Service users involved as participants only. There is no indication that service users were involved in the design of the study or interpretation of the findings.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The study focuses on a reablement service.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. All service user participants were over the age of 18 however the</p>	<p>detail on who these participants were is missing. The findings are limited and are very often not reported in context.</p> <p><b>Overall assessment of external validity:</b> ++</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>techniques.</p> <p><b>Is appropriate consideration given to how findings relate to the context, such as the setting, in which the data were collected?</b> No. The author does not discuss the context in which the research took place or how the findings relate to this.</p> <p><b>Is appropriate consideration given to how findings relate to researchers' influence; for example, though their interactions with participants?</b> No. The author does not discuss their own role or the issue of context bias.</p>	<p><b>Mixed methods component: Is the mixed-methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed-methods question?</b> Partly. Integrating quantitative and qualitative findings is acceptable however the author does not discuss this the rational for this or process for doing so.</p> <p><b>Is the integration of qualitative and quantitative data (or results) relevant to address the research question?</b> Partly. The integration of qualitative and quantitative findings is minimal and the author does not explain when integration occurred and the process by which this was done.</p> <p><b>Is appropriate consideration given to the limitations</b></p>	<p>majority appear to have been over the age of 60 years.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. Details on study settings are unclear however the service appears to have been provided in the service user's home.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. The study reports on a reablement service, a service model described in the 2015 National Audit of Intermediate Care.</p> <p><b>Are the views and experiences reported relevant to the guideline?</b> Yes. The study reports service user and staff views in relation to reablement service.</p> <p><b>Was the study conducted</b></p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<b>associated with this integration, such as the divergence of qualitative and quantitative data (or results)?</b> No. The author does not consider the limitations of integration or discuss divergence.	<b>in the UK?</b> Yes. The study was conducted in Glasgow.	

**4. Hjelle KM, Tuntland H, Førland O et al. (2016) Driving forces for home-based reablement; a qualitative study of older adults' experiences. Health and Social Care in the Community 24, doi 10.1111/hsc.12324**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To describe how older adults experienced participation in reablement.</p> <p><b>Methodology:</b> Qualitative study. Semi structured interviews with 8 older adults.</p> <p><b>Is a qualitative approach appropriate?</b> Appropriate. Because the question seeks to understand subjective experiences.</p> <p><b>Is the study clear in what it seeks to do?</b> Clear. There isn't</p>	<p><b>Is the context clearly described?</b> Clear.</p> <p><b>Was the sampling carried out in an appropriate way?</b> Somewhat appropriate. The participants were recruited from the intervention group of the related randomised controlled trial so they were already positive (and motivated) about reablement. It is also possible that the project leader who recruited participants only asked people who had a good experience of</p>	<p><b>Does the study's research question match the review question?</b> Yes.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. Ethics approval was obtained from the Norwegian Regional Medical Ethics Committee. Participants were invited to participate and those who agreed gave their written consent to the reablement staff before the interviews began.</p>	<p><b>Overall assessment of internal validity:</b> ++</p> <p><b>Overall assessment of external validity:</b> ++</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>a section on 'study aims' but from the introduction it's clear that the authors (rightly) believe research on the experiences of people using reablement is so far lacking. They seek to fill this gap with their own research.</p> <p><b>How defensible/rigorous is the research design/methodology?</b> Defensible. There is a clear account of the purposeful sampling for this study, which is linked to a randomised controlled trial. There's a clear account of the rationale behind data collection, especially conducting 2 interviews, where possible. Analysis is also clearly described and justified.</p> <p><b>How well was the data collection carried out?</b> Somewhat appropriately. The rationale for conducting 2 interviews with some participants is made clearly so it is unfortunate that not all participants were interviewed</p>	<p>or successful reablement. For these reasons the sample may not be entirely representative.</p> <p><b>Were the methods reliable?</b> Somewhat reliable. The data was only collected via 1 method although for some participants more than 1 interview was conducted, providing the opportunity for a deeper understanding of their experiences. Although only means of data collection fails to provide the opportunity for triangulating findings, the authors do discuss their result in the context of other research.</p> <p><b>Are the data 'rich'?</b> Mixed. Findings under some themes are presented and illustrated in more detail than others.</p> <p><b>Is the analysis reliable?</b> Reliable. All 4 authors themed and coded the data. Analysis is clearly described and comprised of 4 main stages:</p>	<p><b>Were service users involved in the study?</b> Yes. Yes as respondents but they were not involved in the design or conduct of the study.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. The focus is older people, rather than younger adults.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes.</p> <p><b>Are the views and experiences reported</b></p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>twice. Also, we are told that a participant's partner and another's daughter were present for the interviews but the reason for this is not given. Data collection and record keeping were conducted systematically.</p>	<p>1. All read each interview as they were carried out and a preliminary analysis started so they could go into more depth in the second interview. Once all interviews had been conducted the transcripts were put together in 1 document and the authors read all interview material.</p> <p>2. 'Meaning units' were identified. These are 'text fragments reflecting participants' experiences of reablement' (p3). Coding was then conducted by identifying and sorting meaning units. Final codes were based on consensus among all authors.</p> <p>3. Transcripts were read systematically to identify and classify the meaning units into thematic code groups.</p> <p>4. Finally, 'data were recontextualised by developing descriptions providing stories that reflected the wholeness of the original context' (p5). Representative text from the transcripts were used to</p>	<p><b>relevant to the guideline?</b> Yes.</p> <p><b>Does the study have a UK perspective?</b> No. Conducted in Norway although the reablement service broadly compares with reablement as delivered and evaluated in the United Kingdom.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>illustrate the trustworthiness of the themes and sub themes.</p> <p><b>Are the findings convincing?</b> Convincing. Findings are clearly presented and supported by quotes from the transcripts.</p> <p><b>Are the conclusions adequate?</b> Somewhat adequate. The conclusions certainly relate to the aims of the study and are clearly linked with the findings and quotes presented. Discussion of practice implications arising from the data are not terribly in-depth and only go as far to say that follow up programmes should be provided to people following a period of reablement (in order to maintain motivation).</p>		

**5. Wilde A and Glendinning C (2012) 'If they're helping me then how can I be independent?' The perceptions and experience of users of home-care re-ablement services. Health and Social Care in the Community 20: 583-90**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To report on the interview study component of reablement service users and carers (part of a wider multi-method study of reablement). Considers the immediate and longer term impact of the service for the recipients and identifies potential barriers to optimal outcomes for these stakeholders.</p> <p><b>Methodology:</b> Qualitative study.</p> <p><b>Is a qualitative approach appropriate?</b> Appropriate.</p> <p><b>Is the study clear in what it seeks to do?</b> Clear.</p> <p><b>How defensible/rigorous is the research design/methodology?</b> Defensible.</p> <p><b>How well was the data collection carried out?</b></p>	<p><b>Is the context clearly described?</b> Not sure. As part of the study, observations of reablement sessions took place - but these are not described (nor in the Rabiee and Glendinning 2011 paper).</p> <p><b>Was the sampling carried out in an appropriate way?</b> Appropriate. As far as can be ascertained.</p> <p><b>Were the methods reliable?</b> Reliable.</p> <p><b>Are the data 'rich'?</b> Not sure. Very little primary data is included, but this is likely to be a restriction for publication.</p> <p><b>Is the analysis reliable?</b> Reliable. Thematic analysis using different levels of construct, with the ability to compare and contrast different sources and interpretations</p>	<p><b>Does the study's research question match the review question?</b> Yes.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. Ethics approval, staged method of consent described.</p> <p><b>Were service users involved in the study?</b> Yes.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. Adults over 18.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes.</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
Appropriately.	through intra-case and cross-case comparison.  <b>Are the findings convincing?</b> Convincing.  <b>Are the conclusions adequate?</b> Adequate.	<b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes.  <b>Are the views and experiences reported relevant to the guideline?</b> Yes. <b>Does the study have a UK perspective?</b> Yes.	

## Review question 4 – Critical appraisal – health, social care and other practitioners views and experiences

### 1. Rabiee P and Glendinning C (2011) Organisation and delivery of home care re-ablement: What makes a difference? Health and Social Care in the Community 19: 495–503

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<b>Study aim:</b> To explore the organisation, content and features of reablement services in 5 local authority sites, and to consider what factors have the ability to enhance or detract from effectiveness.  <b>Methodology:</b> Qualitative	<b>Is the context clearly described?</b> Clear. There is little detail on the observation of the 26 reablement visits (probably for reasons of space in journal reporting).  <b>Was the sampling carried out in an appropriate way?</b>	Does the study's research question match the review question? Yes. Specific to reablement.  <b>Has the study dealt appropriately with any ethical concerns?</b> Partly. Unlike its companion study,	<b>Overall assessment of internal validity:</b> +  <b>Overall assessment of external validity:</b> ++

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>study.</p> <p><b>Is a qualitative approach appropriate?</b> Appropriate.</p> <p><b>Is the study clear in what it seeks to do?</b> Clear.</p> <p><b>How defensible/rigorous is the research design/methodology?</b> Defensible.</p> <p><b>How well was the data collection carried out?</b> Appropriately.</p>	<p>Appropriate. Purposive sampling of local authorities, all of which were 'screened' to ensure they were offering the services of interest, were willing to take part and staff had time to collect data and work with research team.</p> <p><b>Were the methods reliable?</b> Reliable.</p> <p><b>Are the data 'rich'?</b> Mixed. The contexts of the data are described and detailed findings are provided. However, no supporting quotes are provided and this is a shortcoming.</p> <p><b>Is the analysis reliable?</b> Reliable. Framework analysis seems sensible, with data from a range of sites to supply confirming or conflicting data.</p> <p><b>Are the findings convincing?</b> Convincing.</p> <p><b>Are the conclusions adequate?</b> Adequate.</p>	<p>Wilde and Glendinning (2012), ethics approval is not reported. Although involving mostly staff, observation of care in one's own home should have entailed consent.</p> <p><b>Were service users involved in the study?</b> No. But they were in companion study (Wilde and Glendinning 2012).</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
		<p><b>Are the views and experiences reported relevant to the guideline?</b> Yes.</p> <p><b>Does the study have a UK perspective?</b> Yes.</p>	

**Research question 5. Dementia and Intermediate care or Reablement:**

- a) **What is the effectiveness and cost effectiveness of intermediate and reablement for people living with dementia?**
- b) **What are the views and experiences of people living with dementia, their families and carers in relation to intermediate care and reablement?**
- c) **What are the views and experiences of health, social care and other practitioners about intermediate care and reablement for people living with dementia?**

**Research question 5 – Findings table – Effectiveness**

1. Culverwell A and Milne A (2010) Intermediate care: evaluating a specialist home treatment service. *Journal of Dementia Care* 18: 32-5

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> Formative evaluation of the Home Treatment Service for People living with Dementia in Eastern and Coastal Kent (ECK). The aim is to inform the cycle of service improvement and specifically to aid decision making about whether to roll out the service to other parts of East Kent.</p> <p><b>Methodology:</b> Mixed methods. The outcomes reported here are drawn primarily from routine</p>	<p><b>Participants</b></p> <ul style="list-style-type: none"> <li>• Service users and their families, partners and carers - During its first full year of activity, the HTS worked with 148 completed cases</li> </ul> <p><b>Sample characteristics</b></p> <ul style="list-style-type: none"> <li>• Age - Average age of the client group was 82 years with the age range spanning 57 to 98 years. Two thirds of the 148 cases</li> </ul>	<p><b>Narrative findings – Effectiveness</b></p> <p>Only descriptive analyses were conducted which are reported as aggregated totals for user/carer characteristics and as percentages where relationships are discussed. The majority (80%) of referrer’s goals were either ‘fully met’ or ‘partially met’. The goals most frequently achieved were: supporting carer/care staff, avoiding hospital admission,</p>	<p><b>Overall assessment of internal validity:</b></p> <p>-</p> <p><b>Overall assessment of external validity:</b></p> <p>+</p>

<p>data gathered during the HTS's first full year of activity and a 6 month follow up period. It incorporates data from staff records including key characteristics of the user (and carer) population, severity of dementia, referrers' goals, and the Short Form Camberwell Assessment of Need in the Elderly (CANE).</p> <p><b>Country:</b> UK. East Kent only.</p> <p><b>Source of funding:</b> Not reported.</p>	<p>were aged over 80 with a sixth being aged 90 or over.</p> <ul style="list-style-type: none"> <li>• Sex - a third were male and two thirds female.</li> <li>• Ethnicity – Not reported.</li> <li>• Country of birth – Not reported.</li> <li>• Language – Not reported.</li> <li>• Religion/belief – Not reported.</li> <li>• Disability - Over half of cases had a moderate level of dementia, about a third had severe, and a fifth mild. On admission half of the clients were living in their own homes, a sixth were in mental health hospital, and a quarter were in care homes. In terms of the CANE, the most frequently identified unmet needs were: daytime activities, distress, challenging behaviours and carer or care staff need. On average just over 3 unmet needs were identified per client, with the number ranging from 1 to 9.</li> </ul>	<p>conducting an assessment of problems/need, facilitating discharge from hospital, supporting a transition, and engaging the user with services. In relative terms the HTS was less effective at promoting user functioning.</p> <p>Overall, the majority (73%) of all CANE needs identified as unmet on entry to the service were either wholly or partially met at discharge; nearly half were wholly met. A quarter (25%) of unmet needs remained the same and only 2% got worse. For two thirds of users, their location was the same at the end of HTS involvement as it was at the start; a quarter moved to a more supported environment, i.e. from home to a care home or care home to hospital, and a sixth moved to a less supported environment, i.e. were discharged from hospital home or care home, or from a care home to their own home.</p>	
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	<ul style="list-style-type: none"> <li>• Long term health condition – Not reported.</li> <li>• Socioeconomic position – Not reported.</li> <li>• Pension – Not reported.</li> <li>• Living arrangement – Not reported.</li> </ul> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Intervention number - 148 cases accepted to the HTS programme. No comparison cases.</li> </ul> <p><b>Intervention:</b> Home-based community care.</p> <ul style="list-style-type: none"> <li>• Description - Community Mental Health Team works alongside, and augments health and social care services already being provided, reviewing their input and accessing additional services e.g. day care and respite, as required.</li> <li>• Description - The Home Treatment Service (HTS) was set up to provide specialist mental health intermediate care for</li> </ul>	<p>Overall, over two thirds of all those in mental health hospital were discharged after the HTS intervention; two fifths were discharged to their own home and a quarter to a care home. Of those remaining in hospital all were discharged within 3 months of the HTS intervention. At 6 months follow up, of those clients who remained alive, 44% were still living in the same care environment, 37% had moved to a more supported care environment, and 19% to a less supported.</p> <p>The latter group reflects the potential for people with moderate to severe dementia to be rehabilitated i.e. to achieve improved physical and psychosocial functioning and thereby enhance their capacity to live more independently. Significantly, over half of those in their own homes at the beginning of the HTS intervention were still here at follow up and all those whose discharge from</p>	
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	<p>people living with dementia. Consistent with the aims and principles of intermediate care, the HTS works with complex transitions, particularly where a breakdown in the care situation is imminent. It aims to reduce the need for unnecessary moves, particularly to mental health hospital, and to minimise the level of distress should such moves be required. The intention is to enable people to live in the least restrictive and/or most appropriate setting, preferably one of their choosing. The HTS provides a multi-professional comprehensive assessment of need, which informs the provision of a set of interventions focused on meeting the needs of their family carer and/or care staff. It has a distinctive focus on the context of care. The evaluation focused on the</p>	<p>mental health hospital had been facilitated during the HTS intervention, remained out. Almost all of those in specialist residential care also remained there.</p>	
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	<p>impact of the HTS on users and carers, and on the use of acute mental health inpatient services e.g. avoidance of unnecessary admissions, and promotion of timely discharge.</p> <ul style="list-style-type: none"> <li>• Delivered by – Community health team working through the Home Treatment Service.</li> <li>• Duration, frequency, intensity, etc. – The outcomes reported are drawn primarily from routine data gathered during the HTS’s first full year of activity and a 6 month follow up period.</li> <li>• Key components and objectives of intervention – The extent to which the referrer’s goals were achieved and whether the unmet needs identified via CANE on entry to the HTS were met on discharge formed the core of the evaluation.</li> <li>• Location/place of delivery – East Kent, England.</li> </ul>		
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	<p><b>Outcomes measured:</b></p> <ul style="list-style-type: none"> <li>• Service user related outcomes - Incorporates data from staff records including key characteristics of the user (and carer) population, severity of dementia, referrers' goals, and the Short Form Camberwell Assessment of Need in the Elderly (CANE).</li> <li>• Family or caregiver related outcomes- The evaluation also included an assessment of whether carer needs were being alongside those of the user/client.</li> <li>• Satisfaction with services - The extent to which the referrer's goals were achieved and whether the unmet needs identified via CANE on entry to the HTS were met on discharge formed the core of the evaluation.</li> </ul> <p><b>Follow- up:</b></p> <ul style="list-style-type: none"> <li>• Outcomes were assessed during the HTS's first full</li> </ul>		
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	year of activity and a 6 month follow up period.		
	<b>Costs?</b> No.		

## Research question 5 – Critical appraisal – Effectiveness

### 1. Culverwell A and Milne A (2010) Intermediate care: evaluating a specialist home treatment service. Journal of Dementia Care 18: 32-5

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> Formative evaluation of the Home Treatment Service for People living with Dementia in Eastern and Coastal Kent (ECK). The aim is to inform the cycle of service improvement and specifically to aid decision making about whether to roll out the service to other parts of East Kent.</p> <p><b>Methodology:</b> Mixed Methods. The outcomes reported here are drawn primarily from routine data gathered during the HTS's first full year of activity and a 6 month follow up period. It incorporates data from staff records including key</p>	<p><b>Was the exposure to the intervention and comparison as intended?</b> Not reported.</p> <p><b>Was contamination acceptably low?</b> Not reported.</p> <p><b>Did either group receive additional interventions or have services provided in a different manner?</b> Not reported.</p> <p><b>Were outcomes relevant?</b> Yes.</p> <p><b>Were outcome measures reliable?</b> Not reported.</p>	<p><b>Does the study's research question match the review question?</b> Partly. Reports only on the effectiveness of intermediate and reablement for people living with dementia (no views/ experiences).</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Partly. All data are anonymised and numbered, i.e. no user identification data are used in the analysis or the paper. Approval for the service evaluation was obtained via the Trust Clinical Audit and Effectiveness Committee. Not clear if participant consent was gained.</p>	<p><b>Overall assessment of internal validity:</b> -</p> <p><b>Overall assessment of external validity:</b> +</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>characteristics of the user (and carer) population, severity of dementia, referrers' goals, and the Short Form Camberwell Assessment of Need in the Elderly (CANE).</p> <p><b>Is this study a prospective evaluation?</b> Yes, prospective. The outcomes reported here are drawn primarily from routine data gathered during the HTS's first full year of activity and a 6 month follow up period.</p> <p><b>Description of theoretical approach?</b> Partly. Home Treatment Service conducted within model of intermediate care but no theoretical approach described as such. Group allocation.</p> <p><b>How was selection bias minimised?</b> No comparison group.</p> <p><b>Was the allocation method concealed?</b> NA.</p>	<p><b>Were all outcome measurements complete?</b> Not reported.</p> <p><b>Were all important outcomes assessed?</b> Yes.</p> <p><b>Were there similar follow-up times in exposure and comparison groups?</b> NA (no comparison group).</p> <p><b>Was follow-up time meaningful?</b> Not reported.</p> <p><b>Were the analytical methods appropriate?</b> Not reported.</p> <p><b>Were exposure and comparison groups similar at baseline? If not, were these adjusted?</b> NA (no comparison group).</p> <p><b>Was intention to treat (ITT) analysis conducted?</b> Not reported.</p>	<p><b>Were service users involved in the study?</b> No. Neither as co-researchers no participants. Data was obtained from routinely collected information and assessments made by professionals about the users.</p> <p><b>Is there a clear focus on the guideline topic?</b> Partly. The study focuses on the effectiveness of a 'Home Treatment Service' for people living with dementia which includes assessing user goals which include living more independently and avoiding hospitalisation/re-admissions. However, there is no data on cost effectiveness and the data collected do not report on views and experiences of health, social care and other practitioners about intermediate care and reablement for people living with dementia.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Were participants blinded?</b> NA.</p> <p><b>Were providers blinded?</b> NA.</p> <p><b>Were investigators, outcome assessors, researchers, etc., blinded?</b> NA.</p> <p><b>Did participants represent the target group?</b> Yes.</p> <p><b>Were all participants accounted for at study conclusion?</b> Not reported.</p>	<p><b>Was the study sufficiently powered to detect an intervention effect (if one exists)?</b> Not reported.</p> <p><b>Were the estimates of effect size given or calculable?</b> Not reported.</p> <p><b>Was the precision of intervention effects given or calculable? Were they meaningful?</b> Not reported.</p> <p><b>Do conclusions match findings?</b> Yes.</p>	<p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. Study examines adults, aged 18 years and older, living with dementia and with experience of intermediate care and reablement. Also, their families, partners and carers.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. Participants in the programme were in: Dedicated intermediate care and reablement facilities, residential and nursing care homes and people's own homes.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. Includes information about assessment for and planning of intermediate care and reablement that is person centred and identifies needs,</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
		<p>aspirations and social context, including support networks.</p> <p><b>(For effectiveness questions) Are the study outcomes relevant to the guideline?</b> Partly. Covers some but not all the outcomes. The evaluation assesses mostly person centred outcomes related to needs, unmet needs and goals. Also services outcomes by examining the % of users who were admitted and/or avoided hospital care during the length of the intervention and 6 months after the intervention.</p> <p><b>Was the study conducted in the UK?</b> Yes. Intervention is based in East Kent</p>	

**Research question 6. Intermediate care and reablement – information, advice, advocacy, training and support:**

- a) *What is the effectiveness and cost effectiveness of information, advice, advocacy, training and support for people using intermediate care, and reablement and their families and carers?*
- b) *What are the views and experiences of people using intermediate care and reablement, and their families and carers, about information, advice, advocacy, training and support?*
- c) *What are the views and experiences of health, social care and other practitioners about information, advice, advocacy, training and support for people using intermediate care and reablement and their families and carers?*

**Research question 6 – Findings tables – the views and experiences of people using services, their families and carers**

**1. Ariss S (2015) National Audit of Intermediate Care: patient reported experiences. Sheffield: University of Sheffield School of Health and Related Research Care**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> To describe the findings from the qualitative analysis of responses from patients for the 2015 National Audit of Intermediate Care (NAIC). Question asked: ‘Do you feel that there is something that could have made your experience of the service better?’</p>	<p><b>Participants</b></p> <ul style="list-style-type: none"> <li>• Service users and their families, partners and carers as well as people with experience of home and bed based IC and reablement</li> </ul> <p><b>Sample characteristics</b></p> <ul style="list-style-type: none"> <li>• Age - Not reported.</li> <li>• Sex - Not reported.</li> <li>• Ethnicity – Not reported.</li> </ul>	<p><b>Narrative findings – Qual and V&amp;E</b></p> <p>Views and experiences of people using IC&amp;R, and their families and carers, about information, advice, advocacy, training and support.</p> <p>A. People with experience of bed based IC felt improvement needed in provision of information and advice by staff</p>	<p><b>Overall assessment of internal validity:</b></p> <p>-</p> <p>Lack of methodological details.</p> <p><b>Overall assessment of external validity:</b></p> <p>++</p>

<p><b>Methodology:</b> Survey. Questionnaire Survey.</p> <p><b>Country:</b> UK. England.</p> <p><b>Source of funding:</b> Government. NHS England.</p>	<ul style="list-style-type: none"> <li>• Country of birth – Not reported.</li> <li>• Language – Not reported.</li> <li>• Religion/belief – Not reported.</li> <li>• Disability - Not reported.</li> <li>• Long term health condition – Not reported.</li> <li>• Socioeconomic position – Not reported.</li> <li>• Pension – Not reported.</li> <li>• Living arrangement – Not reported.</li> </ul> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Sample size - Responses were received for the 3 types of services: Bed Based, 302; Home-based, 298; Reablement Services, 176: totalling 776 participants.</li> </ul>	<p>1. Appropriate or consistent information about services or care</p> <p>a. People specifically needed better information about their condition, medication and pain management:  “could have received more information about my condition and to my medication”.  “Information about pain” (p9).</p> <p>b. general information needed about the facilities, staff etc.:  “It would be very helpful if, on admission, patients could be given a list of all facilities available. E.g. bathing, hairdressing, newspapers etc.” (p9).</p> <p>c. People with experience of bed based IC gave advice on how information could be provided:  “I think it would be better if other information was in written form. It is quite impossible to remember all that is said in verbal exchanges. I think it would be useful if points raised in discussions were collected in the form of answers to question[s]” (p10).</p>	
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		<p>d. There was concern for people who were less able than herself to ask for information:          “I can't help feeling that I was lucky enough to be able to ask for any information I needed and therefore received” (p10).</p> <p>2. Patient and family communication and inclusion          People with experience of bed based IC felt it important to involve family members in decision making, and sometimes felt pressured into making decisions which my family should be involved in.          “It would have been better to have my wife involved in all discussion about my care once I was able to go home” (p10).          “We as a family never got a straight answer to questions that was asked” (p10).</p> <p>3. Lack of knowledge or understanding of patient's condition or treatment          People with experience of bed based IC felt that physio didn't know their condition.          “The condition of my leg has deteriorated since my stay in X Hospital mainly because up to</p>	
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		<p>date in information of treatment was not relayed. The staff had no knowledge of current treatment” (p18).  “Also information at handover was poor. My file was rarely read!” (p18).  4. Joined up, appropriate, timely &amp; informed services, continuity issues &amp; discharge  “More time to speak to social worker about after care” (p18).  No data on support, training, or advocacy was reported.</p> <p>B. People with experience of home based IC felt improvement in services needed in:  1. Joined-up, appropriate, timely and informed services, for example in Discharge &amp; after care plans. People with experience of home based IC experienced difficulties around discharge arrangements and after-care planning owing to lack of responsiveness of, or lack of communication with after-care services, such as telecare, resulting in an extended stay in hospital.</p>	
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		<p>“My husband and I would like someone to explain what aftercare is available to us, as we are not sure how to proceed” (p20).</p> <p>“Discharged too early before arrangements could be made, on a bank holiday Monday” (p21).</p> <p>2. Timeliness and information about how long to wait, People with experience of home based IC felt that they have a long wait for services to be put in place, delaying discharge from hospital, and a slower recovery. On occasions the information given to patients regarding waiting time was inaccurate. “We had to wait a long time for someone to come” (p21).</p> <p>3. Lack of appropriate, consistent information about services or care a concern. People with experience of home based IC felt they had very little information about the services that they were receiving or could have access to. Contact information for services was also lacking</p>	
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		<p>“Some written information about what exercises to do and some phone numbers to get help from” (p24).</p> <p>“The hospital did not give much info - about the visits. Perhaps a quick phone call to let us know when to expect a visit could have helped. I had to ring the hospital to find out” (p24).</p> <p>4. People with experience of home based IC reported having little or no information about discharge information:  “More information needed to when the services came to an end” (p24).</p> <p>No data on support, training, or advocacy was reported.</p> <p>C. People with experience of Reablement services felt improvement in services needed in provision of information and advice to address lack of appropriate, consistent information about services or care.</p> <p>1. Joined-up, appropriate, timely and informed services related to  2. Continuity issues as potentially confusing for people</p>	
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		<p>with experience of Reablement services to have different aspects of care provided by different teams, suggesting that “One continuous contact point across services from discharge to home care” (p28).</p> <p>3. Critical of discharge arrangements involved planning and organisation on leaving hospital services. “The transition from hospital to home could have been better I didn't have enough information about my condition symptoms - the importance of changing stockings” (p28).</p> <p>4. Organisational problems in Communication, coordination and organisation within and between services, resulting in lack of relevant information being passed between colleagues about patients' conditions or situations. “.....with so many teams involved, I felt your colleagues couldn't keep up with each other along [with] the deterioration of my condition” (p29).</p> <p>5. Clear explanation: “A better explanation of the service at the</p>	
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		<p>beginning. We were very confused and it took a call to the coordinator to explain what was happening. (Different [people] were saying different things)" (p30).</p> <p>6. Timeliness and information about how long to wait. Waiting times for services for some patients considered unacceptable. "It took 5 weeks for the physiotherapist to visit, we have had no support from OT at all" (p29).</p> <p>7. Felt service to be inappropriate for their needs, "The service bore no real relation to how ill I was" (p29). No data on support, training, or advocacy was reported.</p>	
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**2. Hoffmann T and Tooth L (2004) Patient perceptions of the quality of information provided in a hospital stroke rehabilitation unit. British Journal of Occupational Therapy 67: 111-7**

<b>Research aims</b>	<b>PICO (population, intervention, comparison, outcomes)</b>	<b>Findings</b>	<b>Overall validity rating</b>
<p><b>Study aim:</b> The study aimed to explore the extent, source and format of the information received by stroke patients while undergoing rehabilitation, along with their perceptions of</p>	<p><b>Participants</b></p> <ul style="list-style-type: none"> <li>• Service users and their families, partners and carers - Patients who had been discharged from a</li> </ul>	<p><b>Narrative findings – Qual and V&amp;E</b></p> <p>Findings are presented in the following themes:</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b></p>

<p>the quality of that information. The specific aims were to determine:</p> <ol style="list-style-type: none"> <li>1. What written/non-written information was provided during stroke rehabilitation</li> <li>2. Which rehabilitation unit health professionals provided this information</li> <li>3. Patients' perceptions of the quality of this information in terms of: <ul style="list-style-type: none"> <li>– How well it provided the necessary information that they required and whether they wanted more</li> <li>– Whether there were gaps and/or undue repetition</li> <li>– Its relevance to their particular concerns and needs</li> <li>– How it assisted them in coping with the lifestyle and the family reorganisations that occurred following stroke</li> <li>– How easy it was to access, read and/or understand – The readability level of the written information (p112).</li> </ul> </li> </ol> <p><b>Methodology:</b> Qualitative study.</p>	<p>stroke rehabilitation unit in a Brisbane hospital.</p> <p><b>Sample characteristics</b></p> <ul style="list-style-type: none"> <li>• Age - Mean age - 68 years old.</li> <li>• Sex - 53% male and 47% female.</li> <li>• Ethnicity – Not reported.</li> <li>• Country of birth – Not reported.</li> <li>• Language – English speaking only.</li> <li>• Religion/belief – Not reported.</li> <li>• Disability - Not reported.</li> <li>• Long-term health condition – The participants stayed in the rehabilitation unit for a median of 29 days (IQR 14-35). The main types of stroke experienced by the participants were partial anterior circulatory infarcts (40%), lacunar (27%) and posterior circulatory infarcts (13%). Other types, including subarachnoid haemorrhages,</li> </ul>	<p>1. Types of information received and desired: Participants were asked whether they received information and whether they wanted more information on 21 topics which is presented in figure 1 on p113.</p> <ul style="list-style-type: none"> <li>- All participants (n=15) received information about returning home and activities/exercises after stroke, with very few wanting more information (n=3).</li> <li>- 13 participants received further information about equipment/assistive devices and the prevention of strokes.</li> <li>- Participants who wanted more information on the following areas: Treatment after a stroke (n=8), causes of a stroke (n=8), stroke support groups (n=7), prevention of a stroke (n=6) and risk factors for stroke (n=6).</li> <li>- Participants identified additional topics that were not on the original list which were medications and their side effects (n=4), specific medical information about their type of stroke (n=2) and specific symptoms such as dizziness, pain and loss of taste (n=4).</li> </ul>	<p>+</p>
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<p>Qualitative interviews (n=15) were conducted with consenting patients discharged from a stroke rehabilitation unit of a hospital in Brisbane.</p> <p><b>Country:</b> Not UK. Brisbane, Australia.</p> <p><b>Source of funding:</b> Other. University. This study was supported by a University of Queensland New Staff Research Start-up Fund grant (2000).</p>	<p>represented 20% of the strokes. For 87% of the participants, it was their first stroke (p.113).</p> <ul style="list-style-type: none"> <li>• Socioeconomic position – Forty per cent were married, with 33% widowed, 7% single and 20% divorced or separated.</li> <li>• Pension – Not reported.</li> <li>• Living arrangement – Not reported.</li> </ul> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Sample size- n=15.</li> </ul> <p><b>Costs?</b> Not reported.</p>	<ul style="list-style-type: none"> <li>- Most information (19/21 topics) was given to participants verbally with the main source of information coming from occupational therapists or doctors. Additionally, other health professionals i.e. physiotherapists, speech and language pathologists and social workers, gave information to participants.</li> <li>- Written communication, with verbal, was given only on 2 topics – emotional problems and the impact of stroke on relationships.</li> <li>- 60% of participants reported information was given when a family or caregiver was present.</li> <li>- Overall, 70% of participants felt that they had not received enough information after their stroke.</li> <li>- 93% of participants stated their preferred method of information would be through a discussion with health professionals.</li> <li>- 33% identified a preference for written information, additionally 20% further expressed information be cascaded through audio-visual,</li> </ul>	
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		<p>computerised information or stroke education groups.</p> <p>2. Perception of the quality of information received</p> <ul style="list-style-type: none"> <li>- The perception of information received was generally positive, with participants rating 1-10 on the following areas: satisfaction with written information (9); Ease of reading and understanding (8.5); relevance (8); satisfaction with non-written information (8); how the information assisted them to cope with life after the stroke (8); and ease of access (5).</li> <li>- General comments were positive, for example 'giving them the information they needed' (n=8) and 'making it easier for them to do what was expected during recovery' (n=6).</li> <li>- One participant commented that, "I felt more safe and more confident after things were explained to me". Another commented, "it [the information] gave guidelines and helped to decrease my fears and anxieties" (p.114).</li> </ul>	
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		<p>- Conversely, 87% of participants felt that there were gaps in the information which are reported above (see types of information received and desired).</p> <p>3. Readability of written materials - 25 materials were reviewed by the research team for analysis which were generally fact sheets, brochures or posters from stroke organisations (n=14), government departments (n=5), hospital departments (n=5) and pharmaceutical companies (n=1). - SMOG readability level of the 25 materials was at an equivalent grade of 12 (SD 1.5, range 10-15) level of education: 8% at grade 10, 36% at grade 11, 24% at grade 12, 8% at grade 13 and 12% each at grades 14 and 15.</p>	
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## Research question 6 – Critical appraisal – the views and experiences of people using services, their families and carers

### 1. Ariss S (2015) National Audit of Intermediate Care: patient reported experiences. Sheffield: University of Sheffield School of Health and Related Research Care

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> To describe the findings from the qualitative analysis of responses from patients for the 2015 National Audit of Intermediate Care (NAIC). Question asked: 'Do you feel that there is something that could have made your experience of the service better?'</p> <p><b>Methodology:</b> Survey. Questionnaire Survey.</p> <p><b>1. Objectives</b></p> <p><b>Objectives of the study clearly stated?</b> Yes. To describe the findings from the qualitative analysis of responses from patients for the 2015 National Audit of Intermediate Care (NAIC). Question asked: 'Do you feel</p>	<p><b>3. Measurement and observation</b></p> <p><b>3.1 Describes what was measured, how it was measured and the results?</b> Yes. Data driven by views and experiences on the question 'Do you feel that there is something that could have made your experience of the service better?' (Yes or No response), with free text box to give further information.</p> <p><b>3.2 Measurements valid?</b> Yes. Valid qualitative data.</p> <p><b>3.3 Measurements reliable?</b> Yes.</p> <p><b>3.4 Measurements reproducible?</b> Unclear.</p>	<p><b>Does the study's research question match the review question?</b> Yes. Views and experiences of people using IC &amp;R, and their families and carers, about information, advice, advocacy, training and support.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> No. Not reported.</p> <p><b>Were service users involved in the study?</b> Yes. Involved as participants of the study.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. Views and experiences of people using IC &amp;R.</p> <p><b>Is the study population the same as at least one of the</b></p>	<p><b>Overall assessment of internal validity:</b> -</p> <p>Lack of methodological details.</p> <p><b>Overall assessment of external validity:</b> ++</p>

<p>that there is something that could have made your experience of the service better?’</p> <p><b>2. Design</b></p> <p><b>2.1 Research design clearly specified and appropriate?</b> Partly insufficient information on study design. Report was described as a questionnaire survey (quantitative data related to frequency counts on the question of, ‘Do you feel that there is something that could have made your experience of the service better?’ (Yes or No response)). Following this there was a space to provide further information (qualitative data).</p> <p><b>2.2 Clear description of context?</b> Partly. Insufficient information, participants are service users of IC&amp;R</p> <p><b>2.3 References made to original work if existing tool used?</b> Yes. Using coding work that was</p>	<p><b>4. Presentation of results</b></p> <p><b>4.1 Basic data adequately described?</b> Partly. Insufficient data reported.</p> <p><b>4.2 Results presented clearly, objectively &amp; in enough detail for readers to make personal judgements?</b> Partly. Results complemented by quotes from users.</p> <p><b>4.3 Results internally consistent?</b> Yes.</p> <p><b>5. Analysis</b></p> <p><b>5.1 Data suitable for analysis?</b> Partly. Due to insufficient info on survey methodology</p> <p><b>5.2 Clear description of data collection methods and analysis?</b> Yes. Data collected using questionnaires. Analysis of qualitative data using NVivo (V.10).</p>	<p><b>groups covered by the guideline?</b> Yes. People using IC&amp;R.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. Participants in the programme were in: Dedicated intermediate care and reablement facilities, residential and nursing care homes and people's own homes.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes.</p> <p><b>(For views questions) Are the views and experiences reported relevant to the guideline?</b> Yes.</p> <p><b>Was the study conducted in the UK?</b> Yes. England.</p>	
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<p>undertaken in 2014 NAIC report. Changes were made to Coding Themes with 3 sub-themes were added: 'Lack of knowledge or understanding of patient's condition or treatment', 'Social interaction', and 'Cleanliness'. 12 sub-themes were modified to better represent the data.</p> <p><b>2.4 Reliability and validity of new tool reported?</b> Unclear. Not reported</p> <p><b>2.5 Survey population and sample frame clearly described?</b> No. Sampling process not reported.</p> <p><b>2.6 Representativeness of sample is described?</b> No.</p> <p><b>2.7 Subject of study represents full spectrum of population of interest?</b> Unclear. Insufficient information.</p> <p><b>2.8 Study large enough to achieve its objectives, sample size estimates</b></p>	<p><b>5.3 Methods appropriate for the data?</b> Yes.</p> <p><b>5.4 Statistics correctly performed and interpreted?</b> No. Only descriptive statistics used for frequency counts in no. of positive and negative remarks (p3).</p> <p><b>5.5 Response rate calculation provided?</b> No. Not possible for the reviewers to calculate.</p> <p><b>5.6 Methods for handling missing data described?</b> No. Not reported</p> <p><b>5.7 Difference between non-respondents and respondents described?</b> No. Not reported.</p> <p><b>6. Discussion</b></p> <p><b>6.1 Results discussed in relation to existing knowledge on subject and study objectives?</b> Yes. Also</p>		
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<p><b>performed?</b> Unclear. Not reported.</p> <p><b>2.9 All subjects accounted for?</b> Unclear. Not reported.</p> <p><b>2.10 All appropriate outcomes considered?</b> Yes. Views and experiences of people using IC&amp;R to answer a survey question 'Do you feel that there is something that could have made your experience of the service better?' (Yes or No response), respondents used the free text box to give further information.</p> <p><b>2.11 Response rate.</b> Not reported. 776 respondents were involved (Bed Based, 302; Home-based, 298; Reablement Services, 176), but no information on how many were sent questionnaires and not responded (response rate). Not possible to calculate the RR.</p> <p><b>2.12 Measures for contacting non-responders?</b> Not reported.</p>	<p>compared with data from the NAIC Audit 2014.</p> <p><b>6.2 Limitations of the study stated?</b> No. Not reported.</p> <p><b>6.3 Results can be generalised?</b> Partly. Due to insufficient methodological details and nature of qualitative data.</p> <p><b>6.4 Appropriate attempts made to establish 'reliability' and 'validity' of analysis?</b> No. Not reported.</p> <p><b>7. Interpretation</b></p> <p><b>7.1 Conclusions justified?</b> Partly. Due to methodological limitations</p>		
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**2. Hoffmann T and Tooth L (2004) Patient perceptions of the quality of information provided in a hospital stroke rehabilitation unit. British Journal of Occupational Therapy 67: 111-7**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> The study aimed to explore the extent, source and format of the information received by stroke patients while undergoing rehabilitation, along with their perceptions of the quality of that information. The specific aims were to determine:</p> <ol style="list-style-type: none"> <li>1. What written/non-written information was provided during stroke rehabilitation.</li> <li>2. Which rehabilitation unit health professionals provided this information.</li> <li>3. Patients' perceptions of the quality of this information in terms of: <ul style="list-style-type: none"> <li>– How well it provided the necessary information that they required and whether they wanted more</li> <li>– Whether there were gaps and/or undue repetition</li> <li>– Its relevance to their particular concerns and needs</li> </ul> </li> </ol>	<p><b>Is the context clearly described?</b> Clear. Clear contextualisation of patients detailed in results - i.e. information on socio-economic status, age, sex and whether this was a first stroke. However, no consideration on race or religion therefore uncertain of whether the sample is representative of the demographic. Caution to generalise.</p> <p><b>Was the sampling carried out in an appropriate way?</b> Somewhat appropriate. Participants are accessed through the chief occupational therapist over a period of 5 months subject to meeting eligibility criteria. It is not clear whether sampling is purposive or random, whether there is bias. Patients were identified over a period of 5 months by the rehabilitation ward's senior</p>	<p><b>Does the study's research question match the review question?</b> Yes. Paper relates to views and experiences of people who received support after a stroke, about information and advice.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Partly. Ethical clearance was obtained from the University of Queensland and the hospital involved. The paper states that 'All the patients who were approached consented' but no details are provided about how this was achieved.</p> <p><b>Were service users involved in the study?</b> No. Study is not co-produced.</p> <p><b>Is there a clear focus on the guideline topic?</b> Partly. Paper relates to views and</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> +</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>– How it assisted them in coping with the lifestyle and the family reorganisations that occurred following stroke – How easy it was to access, read and/or understand – The readability level of the written information (p112).</p> <p><b>Methodology:</b> Qualitative study. Qualitative interviews (n=15) were conducted with consenting patients discharged from a stroke rehabilitation unit of a hospital in Brisbane.</p> <p><b>Is a qualitative approach appropriate?</b> Appropriate. The paper seeks to explore 15 patients' perceptions of the quality of information provided from a hospital stroke rehabilitation unit, therefore administer a 20-item questionnaire face-to-face. Data is consistent across the interviews because follows same format with opportunities for participants to elaborate.</p>	<p>occupational therapist. Important to note that a requirement to partake was to speak English, thus excluding the perspective of non-English speaking which impacts on the inclusion and equality of all accessing information.</p> <p><b>Were the methods reliable?</b> Somewhat reliable. Data only collected through 1 method - qualitative interviews.</p> <p><b>Are the data 'rich'?</b> Rich. Consistent findings which enable analysis across 21 topics to determine an average of how participants felt about information they received, who gave it to them and what was the accessibility. Data is presented under 3 key findings that appear inductive from the structured questionnaire.</p> <p><b>Is the analysis reliable?</b> Somewhat reliable. Data were analysed using SMOG (a reputable readability formula</p>	<p>experiences of people who received support after a stroke, about information and advice. The nature of the setting and intervention is stroke rehabilitation.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Partly. The nature of the setting and intervention is stroke rehabilitation. Information provided is to re-able stroke victims who are provided information relating to returning home and activities/exercises after stroke.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Partly. Stroke rehabilitation unit of hospital in Australia.</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p><b>Is the study clear in what it seeks to do?</b> Clear. Paper meets the aim which is defined to ascertain what information is provided to patients rehabilitating from a stroke, where the information is cascaded from and ascertaining the views and experiences of how accessible the information is. The paper includes relevant literature to contextualise the current status of the quality of information provided to stroke patients. The underpinning values of the study are cited to explore the effective methods of providing information to stroke patients and conduct a pilot study to examine current practices in information provision in 1 hospital in Australia.</p> <p><b>How defensible/rigorous is the research design/methodology?</b> Somewhat defensible. Thorough eligibility</p>	<p>used in the analysis of health education materials). The quantitative data were descriptively analysed using frequencies, means, standard deviations (SD), medians and interquartile ranges (IQR), using the Statistical Package for Social Sciences (SPSS, version 11.0). The participants' open-ended comments were grouped under common themes. It is not clear how these common themes were determined, whether there was a quality assurance process or how many researchers were involved in the analysis.</p> <p><b>Are the findings convincing?</b> Convincing. Internally quantitative, coherent findings which are supported by open ended comments and clustered to ensure most common response is presented.</p> <p><b>Are the conclusions adequate?</b> Adequate. There is</p>	<p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Partly. The activity is stroke rehabilitation rather than 1 of the 4 IC service models.</p> <p><b>(For views questions) Are the views and experiences reported relevant to the guideline?</b> Yes. Study gathers 15 participants' views and experiences about information received after suffered stroke. Important to note that for most participants this was their first stroke.</p> <p><b>Was the study conducted in the UK?</b> No. Australia.</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>consideration to include participants who are recruited to partake in study. However, could be considered exclusive due to only including English-speaking participants. Recruited through senior occupational therapist but no information on sampling, therefore could be susceptible to bias. Clear aims with thematic findings to highlight practical implications for professional/policy audience.</p> <p><b>How well was the data collection carried out?</b>  Appropriately. Methodology meets research aim to collect the views and experiences of patients (n=15) experiences of returning home after a stroke. The 20-item questionnaire consisted of closed and open-ended questions to be administered face-to-face by the research team, typically interviews lasted 1½ hours. Patients were identified over a period of 5 months by the</p>	<p>a clear link between the data and implications for practice. However, caution to generalise due to small scale study in 1 hospital in Australia. Other hospitals might follow different procedures. Limitations are interwoven in the discussion.</p>		

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>rehabilitation ward's senior occupational therapist. Little consideration of limitations of data collection methodology especially as the eligibility criteria included patients who: - were being discharged to community living (nursing home or care facilities were excluded); - comprehensive understanding of England, so able to give consent; - and, no psychiatric comorbidity that would impact participation (p112).</p>			

**Research question 7.**

- a) What characteristics of intermediate care and reablement service models and approaches are associated with improving outcomes for adults using these services and their families?**
- b) What do adults using intermediate and reablement care services, their carers and families consider to be the important characteristics of service models and approaches?**
- c) What do health, social care and other practitioners consider are the important characteristics of intermediate care and reablement service models and approaches?**

**Research question 7 – Findings tables – Effectiveness**

**1. Ariss S, Enderby P, Smith T et al. (2015) Secondary analysis and literature review of community rehabilitation and intermediate care: an information resource. Southampton: National Institute for Health Research**

<b>Research aims</b>	<b>PICO (population, intervention, comparison, outcomes)</b>	<b>Findings</b>	<b>Overall validity rating</b>
<p><b>Study aim:</b> This review relates to 4 questions, 1 of which matches our review question - To examine the effectiveness of different models of intermediate care, i.e. What team-level factors are associated with the greatest benefits for patients in terms of health status?</p>	<p><b>Participants:</b> Service users and their families, partners and carers.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Older people, (age not reported).</li> <li>• Sex - Not reported.</li> <li>• Ethnicity - Not reported.</li> <li>• Religion/belief - Not reported.</li> <li>• Disability - Not reported.</li> <li>• Long term health condition - Unclear, IC users likely to have long term health conditions.</li> <li>• Sexual orientation - Not</li> </ul>	<p><b>Narrative findings – effectiveness -</b> Results of the systematic review (Data from 5 included studies): Characteristics of service models and approaches to IC: A. Interprofessional/interdisciplinary teamworking (defined as work groups that include more than 2 professional groups of disciplines) - Blewett 2010 (non-RCT, N=339): Patients who received care from an interprofessional team had significantly shorter lengths of stay (20.3 days) than patients receiving care by the traditional model (27 days). These team-level factors were suggested as contributing to these improvements:</p>	<p><b>Overall assessment of internal validity:</b> -</p> <p><b>Overall assessment of external validity:</b> ++</p>

<p><b>Methodology:</b> Systematic review. From the findings of the literature review, secondary analysis of the relationship between structural team-level variables and patient outcomes were conducted Other. From the findings of the systematic review, secondary analysis of the relationship between structural team-level variables and patient outcomes were conducted.</p> <p><b>Country:</b> UK.</p> <p><b>Source of funding:</b> No. Not reported.</p>	<p>reported.</p> <ul style="list-style-type: none"> <li>• Socioeconomic position - Not reported.</li> </ul> <p><b>Sample size:</b> Systematic reviews: number of studies - 5 studies (different designs) included in SR, also used in the secondary analyses.</p> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Intermediate care.</li> <li>• Describe intervention - no details.</li> <li>• Delivered by - health and social care professionals.</li> <li>• Delivered to - older people who used IC.</li> <li>• Duration, frequency, intensity, etc. - no details.</li> <li>• Key components and objectives of intervention - no details.</li> <li>• Content/session titles - no details.</li> <li>• Location/place of delivery - home and bed based.</li> </ul> <p><b>Comparison intervention:</b> One included study compared care</p>	<p>a. team composition- right size and able to counteract negative effects of status differences b. team tenure – a core of the interdisciplinary team had all worked together for several years c. Regular team meetings – to discuss patient care were held several times a week and a formal team meeting was held every 3 weeks d. task allocation – tasks were matched between roles and responsibilities e. cohesiveness – be actively promoted f. open communication – to encourage interdisciplinary team members to share information about both progress and process. Communication a positive aspect of the team. (p52).</p> <p>B. Skill Mix – Dixon 2010 (multivariate analysis of patient data, N=between 337 to 443 patients): This study assessed the relationship between skill mix, patient outcomes, length of stay and service costs in 14 IC team services in England, working primarily with older people. Independent variables included the numbers of different types of staff within a team and the ratio of support staff to professionally qualified staff within teams. It found that an increased skill mix (raising the number of different types of staff by one) is associated with a 17% reduction in service costs (p=0.011). There is weak evidence (p=0.090) that a higher ratio of</p>	
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	<p>from an interprofessional team with care from a traditional single providers (Blewett 2010); one compared the use of an integrated care facilitator (ICF) vs. no ICF (Bird 2010).</p> <p><b>Outcomes measured:</b> Service user related outcomes.</p> <p><b>Follow-up:</b> No details.</p> <p><b>Costs?</b> Cost effectiveness of different models of IC; data not extracted as not part of the review question.</p>	<p>support staff to qualified staff leads to greater improvements in EQ-5D scores of patients.</p> <p>C. Integrated Care Facilitators – Bird 2010 (a comparative study, N= not reported) This study ‘trialled the use of ‘integrated care facilitators’ for patients with COPD and CHF. The study was a collaboration between acute and community-based services to reduce hospital (re)admissions and improve health outcomes in patients who frequently presented to hospitals. The care model was designed by a multidisciplinary care team and involved the co-ordination of care between different disciplines and agencies by the facilitator. Health facilitators undertook a comprehensive assessment of needs using established disease-specific assessment tools. The assessment results were discussed at a case conference and an individual care plan was developed from these discussions. The facilitator then provided information, education and advice to the patient and facilitated the patient’s access to the services they required, including making appointments and ensuring the care was delivered in a way appropriate for the client’ (p53).</p> <p><b>Findings</b></p> <p>1. For COPD patients:</p> <p>a. Emergency readmissions were reduced by 10% in the intervention group (integrated care</p>	
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		<p>facilitators) compared with an increase of 45% in the control group (no integrated care facilitator).</p> <p>b. Hospital admission were reduced by 25% in the intervention group (integrated care facilitators) compared with an increase of 41% in the control group (no integrated care facilitator).</p> <p>c. Length of stay were decreased by 18% in the intervention group (integrated care facilitators) compared with an increase of 51% in the control group (no integrated care facilitator).</p> <p>2. For the CHF patients:</p> <p>a. Emergency readmissions were reduced by 39% in the intervention group (integrated care facilitators) compared with a reduction of 26% in the control group (no integrated care facilitator).</p> <p>b. Hospital admission were reduced by 36% in the intervention group (integrated care facilitators) compared with a reduction of 20% in the control group (no integrated care facilitator).</p> <p>c. Length of stay were decreased by 36% in the intervention group (integrated care facilitators) compared with an increase of 15% in the control group (no integrated care facilitator). Mortality for both intervention arms groups (integrated care facilitators) combined was 18% at 365 days compared with 36% in</p>	
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		<p>the non-intervention groups (no integrated care facilitator). No other team-level factors were tested in the trial.</p> <p>D. Characteristics Of High-Quality Care – Burton 2009 (qualitative study, N=not reported)  This study examined the organisational features staff felt were important for the delivery of high-quality care. Members of multidisciplinary stroke rehabilitation teams (in acute care settings) were interviewed and the following factors were identified as important:</p> <ol style="list-style-type: none"> <li>1. Teamworking, supported by multidisciplinary rounds.</li> <li>2. Supervision and personal development reviews to ensure continuous improvement and development and education and training for staff to access relevant training opportunities.</li> <li>3. Leadership, both internally and externally, a holistic approach to care in which staff get to know patients and understand family and social relationships.</li> <li>4. Communication via multidisciplinary notes and bedside notices can be effective ways of ensuring all staff understand the therapy regime/plan.</li> <li>5. Informal communication was recognised as extremely important and strong interpersonal relationships were vital to ensure effective communication.</li> <li>6. Barrier to effective interdisciplinary</li> </ol>	
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		<p>teamworking included rotation of staff, location of staff and risk aversion (p53).</p> <p>E. Challenges For IC –  Regen 2008 (Qualitative case study, N=61 interviews and N=21 focus groups: p53) The challenges, benefits and weaknesses’ of IC as perceived by patients:</p> <ul style="list-style-type: none"> <li>a. Benefits of IC-flexibility, patient centeredness, promotion of independence, with the ‘home-like’ environment.</li> <li>b. Challenges - at a structural level, workforce and funding shortages, poor collaboration between health and social care agencies and lack of support/involvement from clinicians.</li> <li>c. Weaknesses - insufficient capacity and problems of access and awareness between mainstream care and IC services.</li> <li>d. Service user benefits from the fact that all of the services operated as interdisciplinary teams.</li> </ul> <p>Secondary analysis of data of the above 5 studies (App 3-5, p155-61) This 2-stage secondary data analysis investigated the relationship between 13 different variables at team levels (such as no. of team leaders, management staff, social care staff, domiciliary support staff, clinical support staff and non-clinical staff, % of skilled workers in team) and 6 patient outcomes variables (such as change in TOM [Therapy Outcome Measures] in</p>	
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		<p>impairment, well-being, activity, quality of life, length of hospital stay etc.). A multiple imputational approach was used to address the impact of a substantial amount of missing data.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Skill mix TOM impairment improves more among teams that have a higher skill mix (i.e. larger number of different disciplines: <math>p=0.052</math> for complete case data [ignoring missing data], <math>p=0.050</math> incorporating imputations), with TOM impairment change scores increasing by 0.029 units with each additional discipline represented in the team. (Coefficient 0.029, 95% CI <math>-0.000</math> to 0.057, <math>p=0.052</math> for complete case data; Coefficient 0.032, 95%CI <math>-0.000</math> to 0.065 0.050a: p155).</li> <li>2. Ratio of support staff to professionals <ol style="list-style-type: none"> <li>a. Having more clinical support staff in teams was associated with a small improvement in TOM impairment scores (<math>p=0.025</math> for complete case data, <math>p=0.040</math> incorporating imputations). For every unit increase in clinical support staff, TOM impairment scores increased by approximately 0.01 units; this increase was consistent whether or not the complete case data set or a data set with imputed data was used. (Coefficient 0.010, 95% CI 0.001 to 0.019, <math>p=0.025</math> for complete case data; Coefficient 0.011, 95% CI 0.001 to 0.021, <math>p=0.040</math> incorporating imputations: p155).</li> </ol> </li> </ol>	
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		<p>b. A similar relationship between TOM impairment and number of domiciliary support workers (p=0.030 for complete case data, p=0.023 incorporating imputations) but this was heavily influenced by the data from 1 team. The largest standardised mean TOM impairment change (0.6 units greater than predicted by its case mix) was observed in the team with the highest number of domiciliary staff but removing this data point from the analysis resulted in a substantially reduced (and non-significant) relationship. No significant relationships found between other team variables and outcome variables (well-being, activity, quality of life, length of hospital stay).</p>	
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**2. Smith T, Harrop D, Enderby P et al. (2013) Exploring differences between different intermediate care configurations: a review of the literature. Sheffield: Sheffield Hallam University, University of Sheffield**

<b>Research aims</b>	<b>PICO (population, intervention, comparison, outcomes)</b>	<b>Findings</b>	<b>Overall validity rating</b>
<p><b>Study aim:</b> To explore the relationship between different team characteristics and patient outcomes in intermediate care.</p> <p><b>Methodology:</b> Systematic review.</p>	<p><b>Participants:</b></p> <ul style="list-style-type: none"> <li>• Service users and their families, partners and carers - Some included studies report data including service user views.</li> <li>• Professionals/practitioners - Most of the included studies report the views of practitioners about what the</li> </ul>	<p><b>Effect sizes -</b> Data not routinely reported. Only odds ratios in Fearon et al BUT this is a review of single condition rehab (stroke) and therefore does not meet our review criteria for Q7.</p> <p><b>Narrative findings – effectiveness –</b> Note that none of the included papers directly addressed team level factors that influence outcomes of intermediate care. However most of</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Country:</b> Range of countries.</p> <p><b>Source of funding:</b> Not reported.</p>	<p>team characteristics that contribute to positive outcomes.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - Not reported.</li> <li>• Sex - Not reported.</li> <li>• Ethnicity - Not reported.</li> <li>• Religion/belief - Not reported.</li> <li>• Disability - Not reported.</li> <li>• Long term health condition - This was not systematically reported but the review was searching for IC services supporting older people with multiple morbidities. Some of the single condition interventions included people who had suffered strokes, people with COPD and people with diabetes.</li> <li>• Sexual orientation - Not reported.</li> <li>• Socioeconomic position - Not reported.</li> </ul> <p><b>Sample size:</b> 18 studies: Systematic reviews: Batty (2010),</p>	<p>them mention team characteristics that are associated with positive patient outcomes or staff satisfaction:</p> <ul style="list-style-type: none"> <li>• Supervision and Personal Development, promote and reward - 2 papers</li> <li>• Education and Training - 2 papers</li> <li>• Co-location of team members - 1 paper</li> <li>• Appropriate Staff/Skill Mix - 1 paper</li> <li>• Recruit Staff with IdT skills - 1 paper</li> <li>• Patient Centredness - 3 papers</li> <li>• Holistic approach - 3 papers</li> <li>• Delivery of care at home -one1 paper</li> <li>• Systematic Approach to Quality - 1 paper</li> <li>• Interdisciplinary Teamworking - 18 papers</li> <li>• Interdisciplinary Team Leadership - 2 papers</li> <li>• Team tenure (longer is better) - 2 papers</li> <li>• Team Meetings (regular) - 4 papers</li> <li>• Multidisciplinary Rounds - 1 paper</li> <li>• Multidisciplinary Notes - 1 paper</li> <li>• Effective Communication - 3 papers</li> <li>• Interpersonal Relationships - 1 papers</li> <li>• Flat Team Structure - 1 paper</li> <li>• Team Integration - 1 paper</li> <li>• Goal and Outcome Focus - 1 paper.</li> </ul> <p><b>Narrative findings - qual and v&amp;e –</b> Qualitative studies in the review found ‘indicative evidence that a number of team process</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>Winkel et al. (2008), Trivedi et al., Fearon et al. (2012, Cochrane), Zwarenstein et al. (2009, Cochrane); Literature reviews: Brewer and Williams (2010), Boulton et al. (2009); Empirical studies: Blewett et al. (2010), Jesmin et al. (2012), Roblin et al. (2011); RCTs: Borgemans et al. (2009), Bird et al. (2010); Cross-sectional study: Dixon et al. (2009); Qualitative studies: McClimens et al. (2010), Regen et al. (2008); Mixed methods: Nancarrow et al. (2012), Ryvicker et al. (2011); Case study: Burton et al. (2009).</p> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Interdisciplinary intermediate care teams (although note that not all of the teams featured in the included studies qualify as intermediate care according to the review protocol for RQ7) Only 4 papers addressed factors directly relating to interdisciplinary, intermediate care teams - the others fitted</li> </ul>	<p>variables contribute to better patient care. These include team meetings, inter-team communication, task delegation, role collaboration, patient orientation, team ownership, shared team culture, and clear leadership' (p27).</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>wider definitions of IC.</p> <ul style="list-style-type: none"> <li>• Description - The interventions in the included studies included: Interprofessional care for COPD and CHD Stroke rehab - include ESD IC teams Team based primary care.</li> <li>• Delivered by - A range including nurses, social workers, occupational therapists and physiotherapists, primary care professionals.</li> <li>• Delivered to - Older people, often with multiple morbidities, some with single conditions.</li> <li>• Duration, frequency, intensity, etc. - Not generally specified.</li> <li>• Key components and objectives of intervention - To rehabilitate patients more effectively, facilitate earlier discharge, promote greater independence and prevent readmissions.</li> <li>• Content/session titles - Not specified.</li> </ul>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Location/place of delivery - Mainly home based interventions.</li> </ul> <p><b>Comparison intervention:</b> Care as usual e.g. acute hospital care.</p> <p><b>Outcomes measured:</b></p> <ul style="list-style-type: none"> <li>• Service user related outcomes - Quality of life.</li> <li>• Family or caregiver related outcomes - Caregiver 'strain'.</li> <li>• Satisfaction with services - From both service user and practitioner perspective.</li> <li>• Service outcomes - Length of stay, emergency admissions, re-admissions.</li> </ul> <p><b>Follow-up:</b> In some but not all of the included studies.</p> <p><b>Costs?</b> Some of the included studies reported that the models being evaluated achieved savings (service costs) and 1 systematic review found that early discharge to therapy based rehab "may be cost-effective" if delivered by a</p>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	multi-disciplinary team.		

## Review question 7 – Critical appraisal – the views and experiences of people using services, their families and carers

### 3. Dixon S, Nancarrow SA, Enderby PM et al. (2015) Assessing patient preferences for the delivery of different community-based models of care using a discrete choice experiment. Health Expectations 18: 1204–14

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The aim is 'to assess patient preferences for different models of care defined by location of care, frequency of care and principal carer within community-based health-care services for older people' (p1204).</p> <p><b>Methodology:</b> Surveys. Using the Discrete Choice Experiment approach, a</p>	<p><b>Participants:</b> Service users and their families, partners and carers - Participants were service users who were patients using an Intermediate Care service who had recently been discharged home from hospital.</p> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - All participants 65 or over. 9.1% were aged &lt;70, 37.7% were aged 70-79, 48.0% were aged 80-89, and 5.2% were aged 90+.</li> <li>• Sex - 37.7% were male, 62.3% female.</li> <li>• Ethnicity - Information not provided.</li> </ul>	<p><b>Effect sizes -</b> In the regression analysis, data is provided on how the care preferences of the respondents vary according to their EQ-5D and TOMS scores. In order to allow comparisons to be made, the preferences are shown firstly for all respondents, and then for the following sub-groups of respondents: those scoring EQ-5D&gt;0.5; those scoring EQ-5D&lt;0.5; those whose TOMS measure is less than 3; those whose TOMS measure is greater than or equal to 3; LoC&lt;2; and LoC&gt;1 (LoC data omitted from this summary, as insufficient data provided about what the quoted values mean for interpretation of the measurement). A baseline measure is selected for each parameter, against which participants preferences can be measured. The baseline preference has a coefficient of 0, with a</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>quantitative survey was administered via interviews.</p> <p><b>Country:</b> UK. Unidentified large city within the United Kingdom.</p> <p><b>Source of funding:</b> Government. 'The research was funded by the National Institute for Health Research via its Service Delivery and Organisation research programme' (p1213). This is a government health research funding body.</p>	<ul style="list-style-type: none"> <li>• Religion/belief - Information not provided.</li> <li>• Disability - Information not provided.</li> <li>• Long term health condition - The state of health of the service users was measured using the EQ-5D, on a scale of -0.6 to 1, 'where 1 is full health and 0 represents a health state considered by the general population to be equally preferable to being dead' (p1208). Below 0 is considered to be worse than death. Using this scale, 9.1% measured &lt;0, 13.0% measured 0 to 0.39, 54.5% measured 0.4 to 0.69, and 23.4% measured 0.7 to 1. Only 4/77 participants measured over 0.8.</li> <li>• Sexual orientation - Information not provided.</li> <li>• Socioeconomic position - Not reported. Information not provided.</li> </ul> <p><b>Sample size:</b> 77 service user participants.</p>	<p>negative coefficients suggesting a variable is less preferred than the baseline option, and positive coefficients that it is more preferred. The selected baseline options are: care at home; once a week; with support worker as principal carer.</p> <p>For all respondents, the coefficients are: Outpatients -0.39, P-value 0.003; Hospital -0.77, P-value&lt;0.001; Nursing home -0.95, P-value&lt;0.001; 1 contact pw 0.00; 3 contacts pw 0.02, P-value 0.869; 7 contacts pw 0.03, P-value 0.792; 15 contacts -0.28, P-value 0.018; Support worker 0.00; Nurse 0.22, P-value 0.241; Therapist 0.27, P-value 0.295; Doctor 0.08, P-value 0.701.</p> <p>For EQ5D&gt;0.5: Home 0.00; Outpatients -0.24, P-value 0.095; Hospital -0.64, P-value&lt;0.001; Nursing home -0.80, P-value&lt;0.001; 1 contact pw 0.00; 3 contacts pw -0.1, P-value 0.927; 7 contacts pw -0.6, P-value 0.666; 15 contacts pw -0.34, P-value 0.009; Support worker 0.00; Nurse 0.241, P-value 0.08; Therapist 0.20, P-value 0.498; Doctor -0.01, P-value 0.962.</p> <p>For EQ5D&lt;0.5: Home 0.00; Outpatients -1.0, P-value 0.002; Hospital -1.18, P-value 0.002; Nursing home -1.72, P-value &lt;0.001; 1 contact</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>Intervention category - The study involved service users' views about hypothetical options for 3 aspects of service provision or intervention: location of care, frequency of care and principal caregiver.</li> </ul> <p><b>Outcomes measured:</b></p> <ul style="list-style-type: none"> <li>Service user related outcomes - The outcome measured was the preference of service users receiving Intermediate Care for the delivery of IC in terms of: location (home, nursing home, outpatients or day centre); frequency per week of contacts (1, 3, 7 or 15); and profession of principal carer (support worker, therapist, nurse or doctor). A regression analysis was carried out of the degree to which participants expressed a preference, according to their EQ5D measure of health-related quality of life, and Therapy Measuring Outcome Scale</li> </ul>	<p>pw 0.00; 3 contacts pw 0.14, P-value 0.674; 7 contacts pw 0.61, P-value 0.068; 15 contacts pw 0.02, P-value 0.938; Support worker 0.00; Nurse 1.06, P-value 0.039; Therapist 0.65, P-value 0.293; Doctor 0.42, P-value 0.369.</p> <p>Any TOMS&lt;3: Home 0.00; Outpatients -0.31, P-value 0.125; Hospital -0.32, P-value 0.143; Nursing home -0.73, P-value 0.000; 1 contact pw 0.00; 3 contacts pw 0.01, P-value 0.942; 7 contacts pw 0.18, P-value 0.360; 15 contacts pw -0.16, P-value 0.367; Support worker 0.00; Nurse 0.33, P-value 0.220; Therapist 0.43, P-value 0.234; Doctor 0.28, P-value 0.324.</p> <p>All TOMS&gt;3: Home 0.00; Outpatients -0.69, P-value &lt;0.001; Hospital -1.27, P-value &lt;0.001; Nursing home -1.35, P-value &lt;0.001; 1 contact pw 0.00; 3 contacts pw -0.06, P-value 0.730; 7 contacts pw -0.14, P-value 0.407; 15 contacts pw -0.48, P-value 0.005; Support worker 0.00; Nurse 0.10, P-value 0.708; Therapist 0.02, P-value 0.955; Doctor -0.23, P-value 0.460.</p> <p>The study uses the combined coefficients to rank the 64 possible permutations of care package in order of service user preference; full details of the rankings are not provided, but could be worked out using the table showing the</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>(TOMS) measure of care needs. TOMS measures service' care needs and functioning in relation to impairment, activity, social participation and well-being on a scale of 0-5, with lower scores indicating higher levels of impairment. EQ-5D is quality of life measure based on service user responses, on a scale of -0.6 to 1, with -0.6 indicating the worst possible health.</p> <ul style="list-style-type: none"> <li>• Family or caregiver related outcomes - Family or caregiver outcomes not measured.</li> <li>• Satisfaction with services - Not measured.</li> <li>• Service outcomes - Not measured.</li> </ul> <p><b>Follow-up:</b> There was no follow-up.</p> <p><b>Costs?</b> No. Economic evaluation and cost information were not considered in this study.</p>	<p>regression analysis data. The highest ranked permutation is care at home, 7 times per week, with a therapist as principal carer, which has a linear predicted value of 0.30, and a 95% confidence interval of LPV -0.27 to 0.88. The lowest ranked is care being provided in a residential home 15 times per week by a support worker, which has LPV -1.23 and 95% CI of LPV of -1.60 to -0.86.</p> <p><b>Narrative findings – effectiveness</b>  When participants in the survey were asked to rank different aspects of care as very important/quite important/little importance/not important, the aspect they were most likely to rank as very important was location. Although most carers rated all aspects of care as very important, the aspect which was most likely to be rated as of little or no importance was type of carer. Taking 'home' as the baseline for comparison of placement preference in the regression analysis, it is preferred to other options (outpatients, hospital, nursing home) by all respondents and by all sub-groups of respondents. When contact with caregivers at once per week was used as the baseline for comparison, that level was strongly preferred by all respondents to contact at 15 times per week, but there was a slight preference for contacts to</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		<p>be set at 3 or 7 times per week. The negative response to contacts being 15 times per week was present among all sub-groups apart from those with a lower health-related quality of life where it was slightly preferable to once per week. This group showed a far stronger preference for contact to be set at 7 times per week. Participants with the highest functioning level were the most likely to prefer once per week contact to all other suggested levels. When support worker was the baseline for comparison with other possible caregivers, the response among all respondents was to prefer the other options, with the strongest preference being for therapists. There was a strong preference for the caregiver to be a nurse among those with a low health-related quality of life. The findings indicate a strong preference among all participants for Intermediate Care being provided at home. With regard to level of care and preferred caregiver, these choices can vary according to the service user's circumstances and needs, with service users with poor health preferring nursing care and contact 7 times per week, while those whose functioning is scored at a lower level would prefer a therapist as principal caregiver. Using the values from the linear regression table to rank the different options, the highest ranking</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
		option would be for care to be provided at home, 7 times per week, by a therapist. However, apart from the preference for care being provided at home, the other preferences are not absolute and can vary according to the health and functioning levels of the service users.	

**4. Pearson M, Hunt H, Cooper C et al. (2015) Providing effective and preferred care closer to home: a realist review of intermediate care. Health & social care in the community 23: 577–93**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The aim of the study was to explore what factors need to be taken into account, in terms of service users, practitioners and organisations, when local Intermediate Care services are being designed and delivered.</p> <p><b>Methodology:</b> Systematic review. The study is a 'realist</p>	<p><b>Participants:</b></p> <ul style="list-style-type: none"> <li>• Service users and their families, partners and carers - The reports reviewed deal with service users and their carers.</li> <li>• Professionals/practitioners - The reports reviewed deal with support workers, professionals and service organisers.</li> </ul> <p><b>Sample characteristics:</b></p> <ul style="list-style-type: none"> <li>• Age - 24/38 studies reviewed identify 'older people' as their service user group, although no specific definition of the term is provided.</li> </ul>	<p><b>Effect sizes –</b> Data about effect size in the studies considered in this realist review are not provided.</p> <p><b>Narrative findings – effectiveness</b> The study draws on 38 research studies to identify ways to improve the effectiveness of procedures for delivering Intermediate Care, and describes its findings as a 'roadmap' for delivering this service. It does not prioritise particular features as being more important, or distinguish between necessary and sufficient causes, but suggests that it could be used as a 'diagnostic checklist' (p589) to improve currently existing services. It suggests that Intermediate Care can best achieve its objectives by: making</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>review', a particular form of systematic review which aims to use evidence to address the practical realities and challenges of public policy and practice.</p> <p><b>Country:</b> UK. The study was carried out by UK researchers, and 33/38 studies reviewed were by UK authors.</p> <p><b>Source of funding:</b> Government. The research project was funded by the National Institute for Health Research Service Delivery and Organisation (NIHR SDO), a government body.</p>	<ul style="list-style-type: none"> <li>• Sex - Breakdown of samples by gender is not generally provided, although it is reported that in Dow &amp; McDonald's 2007 study of carers ~90% of the sample was female.</li> <li>• Ethnicity - No data is presented about the ethnicity of the samples.</li> <li>• Religion/belief - No data is presented about the religion or beliefs of the samples.</li> <li>• Disability - No information is presented about the disabilities of the studies' samples.</li> <li>• Long term health condition - 4 studies deal with long term health conditions: 2 with strokes, 1 with COPD and 1 with cognitive impairment.</li> <li>• Sexual orientation - The study makes no mention of sexual orientation.</li> <li>• Socioeconomic position - The socioeconomic position of the studies' samples is not described.</li> </ul>	<p>sure the service user remains the central focus; involving service users and their carers collaboratively in decision-making; making sure this happens at organisational and practitioner level, to help service users develop confidence that their input will be listened to and influential on service delivery; ensuring that the goal is delivering 'proactive, holistic and person-centred care' (p590) rather than responding to crises and economic drivers.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• Systematic reviews: number of studies - 38 studies.</li> <li>• Where participation in the study is recorded or applicable, there were a total of 3896 participants in 30 studies, with the number of participants varying from eight-2,253.</li> </ul> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - The interventions in the sample are community and bed based, and include both admission avoidance (AA) and early supported discharge (ESA).</li> <li>• Description - The realist review does not provide specific information about the types of intervention used in the studies it considers, other than that they all concern the provision of Intermediate Care.</li> <li>• Delivered by - The interventions are delivered by support workers and professionals.</li> </ul>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<ul style="list-style-type: none"> <li>• Delivered to - The service are delivered to people receiving Intermediate Care.</li> <li>• Duration, frequency, intensity, etc. - Information not provided.</li> <li>• Key components and objectives of intervention - The objectives of the interventions were admission avoidance (AA) or early supported discharge (ESD).</li> <li>• Content/session titles - Information not provided.</li> <li>• Location/place of delivery - Service users' homes and other care environments, including residential ESD services.</li> </ul> <p><b>Comparison:</b> This was not a comparison study.</p> <p><b>Outcomes measured</b></p> <ul style="list-style-type: none"> <li>• Service user related outcomes <ul style="list-style-type: none"> <li>- Factors in procedures of delivering Intermediate Care that when present make Intermediate Care 'work'.</li> <li>Measures for assessing</li> </ul> </li> </ul>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>effectiveness of procedures are not presented, but it is likely that different measures were used in the different studies included in the realist review, which would have made it difficult to apply a standardised measure of assessment.</p> <ul style="list-style-type: none"> <li>• Family or caregiver related outcomes - The review presents 1 study where the role of carers in providing Intermediate Care, their relationship with professionals, and difficulties in this relationship that professionals, are described.</li> <li>• Satisfaction with services - No measure of satisfaction is presented, but the review does consider what factors when present in the delivery of Intermediate Care services make them 'work'.</li> <li>• Service outcomes - The service outcome is a 'roadmap' of factors it is recommended that decision-makers should</li> </ul>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>consider when designing Intermediate Care services, so as to maximise their effectiveness in any local context.</p> <p><b>Follow-up:</b> There is no data about follow-up time periods of the studies in this realist review.</p> <p><b>Costs?</b> No. There is no economic evaluation or cost information.</p>		

**5. Wilson A, Richards S, and Camosso-Stefinovic J (2007) Older people's satisfaction with intermediate care: A systematic review. Reviews in Clinical Gerontology 17: 199–218**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The aim of the review was to explore service user satisfaction of older people being provided with Intermediate Care.</p> <p><b>Methodology:</b> This is a systematic review of 31 studies</p>	<p><b>Participants:</b> The review selected only papers which were studies of service user satisfaction or captured service users' views about Intermediate Care. Where there were views and satisfaction of partners and carers in the studies, these are not reported.</p> <p><b>Sample characteristics</b></p> <ul style="list-style-type: none"> <li>Age - The review reports that</li> </ul>	<p><b>Effect sizes</b></p> <p>In RCTs:  Rudd (1997) found 79% with IC v 65% in control group satisfied with hospital care (p=0.032); 58% receiving IC satisfied with therapy provision v 51% (p=0.29); 56% v 50% satisfied with community support (p=0.44); and 59% vs. 48% satisfied in general (p=0.14).  Holmqvist (1998) found IC group had higher satisfaction for 'active participation in programme</p>	<p><b>Overall assessment of internal validity:</b> -</p> <p><b>Overall assessment of external validity:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>dealing with user satisfaction of older people being provided with Intermediate Care.</p> <p><b>Country:</b> Range of countries. The review was carried out by academics from UK universities, but included 14/31 studies from non-UK countries (Australia 5, New Zealand 2, US 2, and Sweden, Spain, Norway, Thailand and Canada 1 each) with 1 country unspecified).</p> <p><b>Source of funding:</b> Not reported.</p>	<p>in the 15 Randomized controlled trials the average age of service users in all but 2 trials was over 65. In all 5 non-randomized studies with a comparison group, the average age of service users was over 65. In the 11 case series and qualitative studies, 4 give a mean age of over 65. One specifies an age range of 22-76; 1 states that 20 (30%) are aged over 60; 1 states that 89% of participants were aged 65 or over, 1 gives a mean age of 58; 1 provides a median age of 76; and in another the mean age is not stated.</p> <ul style="list-style-type: none"> <li>• Sex - Information not provided.</li> <li>• Ethnicity - Information not provided.</li> <li>• Religion/belief - Information not provided.</li> <li>• Disability - Three studies were of service users with acute exacerbations of chronic obstructive pulmonary disease, or COPD. People with this condition may be classified as</li> </ul>	<p>planning' (p=0.021), but in other domains there was no difference.</p> <p>Shepperd (1998) provided the % difference in satisfaction with IC v control for different treatments (95% CI): hip 36 (55, 15); knee 34 (54, 15); hysterectomy 19 (30, 8); elderly medical 41 (62, 20). For COPD it states no difference and CI data not provided.</p> <p>Richards (1998) found more favourable response to 'discussions with staff' (47.4% v 27.7%) but no difference in other questions.</p> <p>Caplan (1999) using lower scores to denote greater satisfaction found mean greater satisfaction with IC than with control group treatment: IC 1.1 (95% CI 1.1, 1.2), control 2.0 (1.7, 2.3) p&lt;0.000.</p> <p>Wilson 2001 found responses to 5 questions favoured IC over control (P&lt;0.05), 1 there was no difference. Scores Intervention 15, control 12 P&lt;0.01.</p> <p>Ojoo (2002) found no between-group difference in mean score: intervention 91.7%, control 88.1% p=NS. Intervention group favoured home care 96.3% vs. 59.3% p=0.001.</p> <p>Crotty (2002) found no difference between groups in median satisfaction scores. Hernandez found higher mean satisfaction scores in IC group, 8.0 vs. 7.5 p&lt;0.03.</p> <p>Bauz-Holter (2004) found satisfaction ratings of</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>disabled in the UK.</p> <ul style="list-style-type: none"> <li>• Long term health condition - The majority of the studies were of service users with non-specific or general health issues, or were being provided with IC following a fracture or an operation. Five were studies where the service users had had a stroke, 3 where they had COPD, 1 where they cellulitis, and 1 where they had breast cancer.</li> <li>• Sexual orientation - Information not provided.</li> <li>• Socioeconomic position - Information not provided.</li> </ul> <p><b>Sample size:</b></p> <ul style="list-style-type: none"> <li>• 31 studies included: 15 RCTs, 5 Non-RCTs, 11 case series/qualitative studies. 30 included studies provided clear details of number of participants. A total of 3106 received the intervention, and 1437 were in control groups. The systematic review presented data about 1 study</li> </ul>	<p>75% vs. 48% favouring IC p=0.06.</p> <p>Corwin (2004) found no difference in overall satisfaction p=0.12, but IC patients scored more highly on location of care p&lt;0.0001 and IC recipients' preference for home care was stronger p&lt;0.0001.</p> <p>Donnelly (2004) found higher satisfaction scores in IC group: mean satisfaction (SD) was 10.72 (1.44) vs. 9.70 (2.09) and mean overall satisfaction was 50.0 (9.66) vs. 11.19 (42.62) p=0.001.</p> <p>Wells (2002) found no differences in satisfaction scores for all dimension p=NS, but more IC would opt for the care they received again (88% vs. 69%, p&lt;0.0001).</p> <p>Harris (2005) found % IC recipients rated services good or excellent 83.0 v 72.5 p=0.05, 95.7 vs. 91.3 not feeling under pressure (p=NS) and 94.8 v 96.5 would recommend to others (p=NS).</p> <p>Caplan (2006) found man (SD) scores higher in IC group: 4.66 (0.64) vs. 4.06 (0.94) p=0.0057.</p> <p>In non-randomised studies:  O'Cathain (1994) found no difference between IC and control groups in satisfaction.  Rink (1998) compared before and after participating in the scheme: pre-scheme 50% complained about transport and 40% about time</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>in a way that did not make clear how many service users participated.</p> <ul style="list-style-type: none"> <li>Comparison numbers - The numbers in the control groups in the RCTs reviewed are: 164, 40, 49, 39, 124, 46, 17, 81, 49, 97, 30, 32, 101, 40, 99, 54, 54, 142 and 34: total 1392, mean no. of participants 73 The numbers in the control groups of studies with non-randomised designs are 28, 60 and 57: total 145, mean no. of participants 48. In 2 of these studies no control group numbers are given. Total in control groups: 1437. There are no control groups in the qualitative studies.</li> <li>Intervention number - In the RCTs, the numbers receiving the intervention are: 167, 41, 37, 47, 114, 50, 15, 160, 51, 102, 30, 34, 121, 42, 101, 59, 54, 143 and 70. Total 1438, mean no. participants per study 76. In the non-randomised studies, the</li> </ul>	<p>of day of discharge; afterwards, 17% and 15%. No difference in satisfaction with medication or adequacy of care plan on discharge. Boston (2001) found higher satisfaction from IC group in response to 19/20 questions across all domains (staff, communication, facilities, other) <math>P &lt; 0.05</math>. Leff (2006) found higher satisfaction with IC group in 5 domains (physicians <math>p = 0.007</math>, other staff <math>p = 0.042</math>, convenience/comfort <math>p = 0.0003</math>, admission <math>p = 0.0003</math> and overall satisfaction <math>p = 0.034</math>), but no significant difference in 4 domains (nurses, pain control, safety, discharge), and no difference in % who would choose care in the same setting again or who would recommend to others.</p> <p><b>Narrative findings – effectiveness</b> Of the 18 studies comparing service users receiving Intermediate Care with those receiving usual care, 13 'observed statistically significant differences in evaluative satisfaction scores (overall evaluations, or for component scores)' (p212) favouring IC, with the rest observing no difference. 'All studies employing preference measures observed stronger preferences for home-based care' (p213).</p> <p><b>Narrative findings - qual and v&amp;e</b></p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>numbers receiving the intervention are: 64, 67, 132 and 84, with 1 where the number of participants is unclear. Total 347, mean no. participants per study where numbers provided 87. In the case series and qualitative studies, the numbers receiving the intervention are: 91, 67, 29, 84, 32, 50, 16, 20, 60, 843 and 29. Total 1321, mean no. participants per study 120. Total receiving intervention in all studies: 3106. Mean no participants per study where numbers are given: 86.</p> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - The intervention was community or bed-based, multi/inter-disciplinary support designed to avoid hospital admission and facilitate hospital discharge. This service is termed Intermediate Care.</li> <li>• Delivered by - Specific information about who</li> </ul>	<p>Qualitative papers reviewed showed a preference for care being provided in the service user's home. Reasons included convenience, comfort, closeness to family and more personalised service delivery. However hospital could feel like a safer environment for patients with some conditions, as service users' main priorities were recovery and survival.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>delivered the services in the studies reviewed is not provided.</p> <ul style="list-style-type: none"> <li>• Delivered to - The participants in the studies receiving the intervention were all being provided with Intermediate Care, and were mostly older service users. The control group participants were hospitalised, or were described as receiving 'usual care'.</li> <li>• Duration, frequency, intensity, etc. - Information not provided.</li> <li>• Key components and objectives of intervention - The key component of the intervention was that care was being provided to people who would otherwise have been in hospital. The objective of the intervention was to avoid hospital admission or facilitate hospital discharge.</li> <li>• Content/session titles - Details about the content of the interventions is not provided.</li> <li>• Location/place of delivery - 22 studies specify that the</li> </ul>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>services were being provided at home. In 5 others it is likely that the location of service delivery was at home, although this is not specified, e.g. early discharge or outreach schemes. Three were in specialist units, and 1 was in hospital and home.</p> <p><b>Comparison:</b> In the studies where there was a comparison, it was between service users being provided with Intermediate Care and those receiving services in hospital or being provided with 'usual care' services.</p> <p><b>Outcomes measured:</b></p> <ul style="list-style-type: none"> <li>• Service user related outcomes <ul style="list-style-type: none"> <li>- The outcome measured was the satisfaction of older service users being provided with Intermediate Care.</li> </ul> </li> <li>• Family or caregiver related outcomes - Family and caregiver related outcomes were not measured.</li> <li>• Satisfaction with services - The</li> </ul>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>quantitative studies used questionnaires and interviews to measure service user satisfaction with services provided to them, including satisfaction with Intermediate Care overall and with components including therapy, community support, active participation in programme planning, location of care, transport arrangements, whether care was well coordinated, communication, nurses/staff, pain control, safety, discharge and whether they would recommend the service to others.</p> <ul style="list-style-type: none"> <li>• Service outcomes - Service outcomes not measured.</li> </ul> <p><b>Follow-up:</b> Only 1 study (Cunliffe 2004) used follow-up interviews, carrying out interviews before hospital discharge and then 4 weeks and 3 months later.</p> <p><b>Costs?</b> The review does not include cost information or an</p>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	economic evaluation.		

## Research question 7 – Findings tables – Health, social care and other practitioners’ views and experiences

### 6. Barton P, Bryan S, Glasby J et al. (2006) A national evaluation of the costs and outcomes of intermediate care services for older people: final report. University of Birmingham: Health Services Management Centre

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b></p> <p>1. To establish the range, spread and speed of development of intermediate care services across England (data not relevant to review question).</p> <p>2. To explore the views of intermediate care leads on the benefits and challenges of implementing intermediate care policy.</p> <p>3. To assess the</p>	<p><b>Participants:</b></p> <ul style="list-style-type: none"> <li>• Service users and their families, partners and carers - Adults who used IC services.</li> <li>• Professionals/practitioners - managers, clinicians, front line staff.</li> </ul> <p><b>Sample characteristics</b></p> <ul style="list-style-type: none"> <li>• Age - IC managers and staff: age not reported. People using IC services were adults: Age not reported.</li> <li>• Sex - IC managers and staff: not reported. People using IC services: not reported.</li> <li>• Ethnicity - IC managers and staff: not reported. People using IC services: not reported.</li> </ul>	<p><b>Narrative findings - qual and v&amp;e</b></p> <p>Quantitative data from survey to establish the range, spread and speed of development of intermediate care services across England (data not relevant to review question) Combined qualitative data from postal survey of IC coordinators (ICC) and from IC managers, clinicians, front line staff in case study from 5 sites (Views on the benefits and challenges of implementing intermediate care policy):</p> <p>A. Drivers and facilitators in the development of intermediate care:</p> <p>a) The need to resolve the systemic problem of delayed discharges or ‘bed-blocking’: “If we can reduce our activity in the acute trust then we can divert resources to support our own services. That flow through intermediate care is crucial to help us ... by keeping beds free” (Site D, p64).</p> <p>b) Partnership working between health and</p>	

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<p>impact of intermediate care on the service system as a whole and on individual service users (p8).</p> <p><b>Methodology:</b> Mixed methods. 1. Postal surveys (qualitative). 2. Case studies (qualitative). 3. Patient satisfaction survey.</p> <p><b>Country:</b> UK.</p> <p><b>Source of funding:</b> Government. Department of Health and the Medical Research Council</p>	<ul style="list-style-type: none"> <li>• Religion/belief - IC managers and staff: not reported. People using IC services: not reported.</li> <li>• Disability - IC managers and staff: not reported. People using IC services: not reported.</li> <li>• Long term health condition - IC managers and staff: not reported. People using IC services: not reported.</li> <li>• Sexual orientation - IC managers and staff: not reported. People using IC services: not reported.</li> <li>• Socioeconomic position - IC managers and staff: not reported. People using IC services: not reported.</li> </ul> <p><b>Sample size:</b> Postal survey of intermediate care co-ordinators: N= 106 (i.e. 46% of 232 PCTs for which contacts had been identified, and 36% of the sample frame of 297 PCTs). Case studies of intermediate care (one-to 1 interview and focus groups with senior managers, service managers and 'frontline' staff</p>	<p>social services, good relations between health and social care staff at service delivery level to progress “I think it’s the only way to have a range of services to actually slot in together and I think especially intermediate care which is really not just social care, it’s very much social care plus, so it makes sense and I think it’s extremely difficult to do it without it being a joint process” (Site A, p64).</p> <p>c) The national policy context for intermediate care “Certainly the NSF and then the subsequent intermediate care guidance really focused everybody’s minds within the service and within the organisation as a system to really try and think a bit more systematically about what we were doing” (Site A, p65).</p> <p>d) Local ‘champions’ for intermediate care, i.e. individuals with some influence, actively involved in the promotion and delivery of intermediate care services: “He (a clinician) was the only person that was really very supportive and keen for it to carry on [...] he was putting in a good word really and saying he wanted to continue to work with the services” (Site A, p65).</p> <p>e) Perceived benefits for patients, developing ‘patient-centred’ services that promoted patient choice and independence: “It is about enabling people to stay in their own homes [...] Meeting what the customer wants” (Site C, p65).</p>	

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	<p>within the 5 case-study sites): N= 82 Patient satisfaction survey: N= 843 (of a total of 1470 completed episodes of care, a response rate of 57%).</p> <p><b>Outcomes measured:</b></p> <ul style="list-style-type: none"> <li>• Satisfaction with services</li> <li>• Service outcomes</li> </ul> <p><b>Costs?</b> Data NOT extracted: not within scope of Q7</p>	<p>B. Barriers to the development of intermediate care:</p> <p>1a) Poor partnership working between health and social care, i.e. competing organisational priorities and 'cultural' differences between PCTs, acute trusts and social services departments. "Separate 'political agendas', organisations saying they are committed but actually adhering to their own agendas, consequently putting up barriers to IC progress" (Postal survey- ICC, p67). "...it still feels to me like there's quite a bit of potential in-fighting between social services and [the] PCT about who owns it..." (Site E, p67).</p> <p>1b) Different employment conditions for health and social services staff doing similar jobs within intermediate care teams had been problematic, also different policies held by health and social services organisations with respect to health and safety issues ".....if you were working say with rehab assistants or working with home care staff because there are certain policies in terms of manual handling that they are not allowed to do certain things that makes life quite difficult ..." (Site C, p67).</p> <p>1c) Incompatibility of health and social services IT systems and the inability of staff to access 'each other's' systems: "But computers don't talk</p>	

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		<p>to each other, we have problems, we are not allowed access to social services computers because I'm health employed so we have to fax everything across instead of getting it off the computer..." (Site E, p67).</p> <p>1d) The desire of organisations for autonomy and to retain control of their own budgets. The existence of separate budgets (as opposed to joint or pooled budgets) was identified as a hindrance to joint working: ".....Everybody is all for joint working and collaboration until you start asking people to give over... money and that is a constant tension and I think perhaps has stood in the way of really making good progress and having a more flexible model" (Site A, p67).</p> <p>2. Insufficient funding for intermediate care: with monies for intermediate care not 'ring-fenced', this affects recruitment of qualified staff, care workers and rehabilitation assistants, also beds/place, operating hours etc.: 'Resources hinder the development as there is not enough funding available through the Local Development Plan to allow the development of comprehensive domiciliary intermediate care services' (Postal survey- ICC, p67).</p> <p>3. Staff shortages and recruitment problems, such as in rural areas, mainly due to lack of sufficient funding and low wages ".....but when</p>	

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		<p>people can get the same sort of salary for a nice sanitized job, then some of the work is not very attractive” (Site C, p67).</p> <p>4. Perceived ‘inflexibility’ of some intermediate care staff and resistance to performing new tasks or delegating work to other professionals or support staff had resulted in a ‘professional protectionism’ that was incompatible with multi-disciplinary working.</p> <p>5. Perceived resistance from the acute sector and medical profession, the acute sector and GPs felt they had been excluded from discussions about setting up intermediate care services due to genuine concerns about the lack of real evidence for intermediate care. “GPs were disinterested because they saw it as they were going to be bleeped every time the drip didn’t work and there wasn’t the medical support for it (Site B).</p> <p>3. Difficulties associated with the national policy context.</p> <p>3a) The government’s ‘official’ definition of intermediate care (Department of Health, 2001a) and its emphasis upon intermediate care as a time-limited (no longer than 6 weeks) intervention posed a particular challenge to those services that pre-dated the 2001 guidance. There was a great deal of variation in how the definition had been implemented: “I</p>	

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		<p>think we still have differences of what intermediate care is..... I know I have a different perception of what I think intermediate care is to perhaps the director of ops or someone in social services, so I still don't think we have properly defined what is intermediate care.. and what interventions are appropriate to be called under that banner" (Site D, p73).</p> <p>3b) Use of targets and performance measures regarding intermediate care also a barrier: "Each organisation has independent targets/performance measures they need to focus on hence less time and commitment for intermediate care which could benefit all" (Postal survey- ICC, p73).</p> <p>C. Strengths/benefits of intermediate care (I interpret this as what IC should be like, i.e. the positive features/characteristics which benefit users and practitioners and the system- Irene).</p> <p>1. Benefits for service users:</p> <p>1a) Both in terms of the experience or quality of the service and in terms of outcomes, particularly when compared with more 'traditional' forms of care. In particular the patient-centred nature of intermediate care and its ability to provide personalised care to suit individual needs: "They get like a one to one service. .... They get individual attention whether</p>	

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		<p>it's from us, whether it's from their own district nurse in their own home and they thrive on it" (Site A, p74).</p> <p>1b). The flexibility and level of input provided by intermediate care services were identified as key components of the holistic approach which was perceived to bring benefits to service users: "We are very flexible in that we will move between hospital, community, you know, the places that we work to deliver intermediate care are vast and we don't have to hand the patient over to anybody else – we've got seamless care" (Site D, p74).</p> <p>1c) The 'homely environment' in which intermediate care services were delivered, generally regarded as being beneficial, particularly in achieving outcomes such as independence and increased confidence: "To think that those older people can stay in their own homes. They still have their independence [...] they can have that level of independence is quite an achievement." (Site D, p74). "You find somebody who's been in hospital for 6 weeks, they've never made themselves a cup of tea... or a sandwich...or a cooked meal or anything, and when they come home .....They've been away from the home for so long it doesn't feel like their home, I've had that said to me, 'It doesn't feel like my home any more, I don't know where</p>	

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		<p>anything is” (Site B, p75).</p> <p>1d) By delivering services in an individual’s own home, the ‘upheaval’ and potential for confusion in response to unfamiliar hospital surroundings could be avoided. Service users could retain much valued social support networks and social activities, essential to their rehabilitation: “... if somebody wants to be able to go to Bingo or to visit a relative that wouldn’t be addressed on a ward where as in our team you have got the capabilities to do that. There are more realistic goals, genuine goals, motivations” (Site A).</p> <p>1e) It was seen as being more conducive to encouraging involvement by patients in their rehabilitation plans and goal setting. By being ‘on their own territory’ both patients and their relatives had more influence over the care process, when compared with hospital settings: “It’s time limited, they know what they’re aiming for, we know what they’re aiming for and asking them what they want to achieve while they’re here” (Site D, p75).</p> <p>2. Benefits for staff:</p> <p>2a) The positive nature of multi-disciplinary (and inter-disciplinary) team working was reported as a clear strength within many intermediate care services, crucial in delivering a flexible and responsive service to users. Interviewees spoke</p>	

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		<p>positively of the support they received from fellow team members and of being able to access expertise from a range of professionals: "...in this team we've got really expert people who know an awful lot and I think we achieve much better outcomes for our patients in terms of therapy input, aides, adaptations, more imaginative solutions and that's a combination of several heads ..... and I just don't think you get that in other systems" (Site A, p76).</p> <p>2b) Operating within a multi-disciplinary or interdisciplinary environment was seen as a pre-requisite for the delivery of holistic, patient-centred care. Many professionals welcomed the opportunities for role flexibility in the intermediate care setting: "... I wouldn't just go out there and do my nursing tasks, which would happen on a ward..... You couldn't have that happening going out to see the patient in the home. So if they're having to carry out an exercise programme then it would be expected of me as a nurse to go through that exercise programme with them on behalf of the physio" (Site A, p76).</p> <p>2c) With team working and, involvement with intermediate care, staff perceived increased levels of autonomy and opportunities to be involved in the development of innovative services. This increased job satisfaction gained</p>	

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		<p>from being involved in the delivery of intermediate care, linked with the goal of restoring or maintaining the independence of service users: “The challenge to me is to get that person up and running again” (Site E, p76).</p> <p>3 Benefits for the whole system:  3a) The ‘whole-systems’ working both in terms of process and outcomes to strengthen the integration and interconnectedness with ‘mainstream’ services, to foster closer working between intermediate care services and between intermediate care and ‘mainstream’ services and establish clear access points, providing effective referral and care pathways for patients before and after intermediate care, a ‘seamless’ experience for patients: “The link with community hospitals is a crucial one and we have staff who can pick somebody up during their admission and then see them through back into the community until they are discharged into intermediate care. So those links, as far as the patient pathway continuity goes, are good” (Site D, p78).</p> <p>3b) Many who was involved in the management and delivery of intermediate care were convinced that their services had resulted in fewer inappropriate admissions to acute and long-term care, making an important contribution</p>	

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		<p>to capacity within health and social care systems: “We think it saves the health service a lot of money and we can put in a few weeks of very intensive support, get them back on their feet again and they have never had the unpleasantness of spending time in a hospital ward” (Site C, p78).</p> <p>D. Weaknesses of intermediate care  1) Capacity issues, mainly relate to funding and resources (see funding and staff recruitment above, i.e. shortage of professional and non-qualified staff resulting from insufficient resources and recruitment problems), also to inability to provide care or to respond to referrals outside hours and on weekends “We can’t provide that service, that may be another reason why the patient had to go into hospital” (Site C, p80).  1a) A lack of care workers and rehabilitation assistants, non-qualified assistants staff was the difficulty in ensuring that such staff always operated within a culture of reablement: “The main challenge has been staffing and encouraging staff to develop an enabling culture rather than a ‘doing-to’ culture..... They’ve struggled with sometimes not doing things for people and encouraging them to do it for themselves” (Site B, p79).</p>	

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		<p>1b) Shortage of home care provision, in particular, domiciliary care with patients who could otherwise receive intermediate care in their own homes but were sometimes admitted to hospital as a result: “Sometimes getting home care is difficult and sometimes non-available ..... has led to people being admitted when they don’t really need to be.” (Site D, p79).</p> <p>1c) Intermediate care services becoming ‘blocked’ due to unavailability of home care services</p> <p>1d) Lack of out-of-hours IC provision (outside the 9.00-5.00 Monday-Friday period) a significant weakness and deterrent to using intermediate care, particularly for GPs.</p> <p>2) ‘Whole-systems’ working.</p> <p>2a) Effective integration with mainstream services:</p> <p>i) Under use and the inappropriate use of intermediate care. Many GPs and hospital staff lacked awareness and understanding of intermediate care services, the lack of a clear access point was regarded as a significant barrier to use for GPs who, under pressure, were likely to ‘default’ to admitting patients to hospital: “It is still perceived as a bit of an add on and to a certain extent we still have a legacy of these projects and short termisms...” (Site A,</p>	

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		<p>p81). "... Having to sit in somebody's house and phone several different places and have various different time scales etc., etc. To not be able to leave the house with a plan organised, that is the main problem" (Site A, p81).</p> <p>ii) Despite attempts to promote intermediate care locally, the concept of IC failed to become embedded within the mindsets of many mainstream practitioners, resulting in under-use of the IC services. The availability of IC still needed to be heavily promoted.</p> <p>iii) Eligibility criteria for intermediate care often perceived as being too narrow by mainstream practitioners, sometimes seen as being rather 'elitist' with accusations of 'cherry-picking', unhelpful and viewed negatively by hospital staff. Recurring difficulties in getting patients admitted to intermediate care meant that practitioners reverted to using more traditional forms of care, i.e. hospital admission. "... hospital staff being prepared to take the risk and discharge somebody to something new that is relatively untested and unknown...So it is starting to overcome those barriers. Part of it is actually once somebody has put a patient through intermediate care then they have got the confidence to do it again" (Site D, p82).</p> <p>iv) Inappropriate use of intermediate care services. Hospital services were felt not to fully</p>	

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		<p>appreciate the nature of intermediate care, therefore making inappropriate referrals and potentially distorting the role of intermediate care. IC staff were concerned that intermediate care was becoming dominated by an acute care agenda, and that they had to regularly 'fight off' the acute sector but admitted that there were occasions when inappropriate referrals had been accepted where capacity allowed it. "We do get quite a high percentage of people who are destined for a nursing home or a residential home and it's 'oh, can't you take this person because they're blocking our acute bed' .....They don't have an understanding of all the input that's available to them [patients]" (Site A, p83). (At the time of the report, the authors noted that while those sites that had implemented a single point of access and clear screening mechanisms generally perceived that their levels of inappropriate referrals had improved as a result.)</p> <p>3) Service development and delivery issues.  3a) IC staff experienced difficulty in achieving collaboration and faced the challenge of bringing together a set of individual services, some of which had operated independently for several years, into a wider framework or 'umbrella' of intermediate care provision. This lack of integration manifested itself in having poor</p>	

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		<p>knowledge of other intermediate care services and to working more flexibly: “I think the weaknesses in terms of the linking, the weaknesses are around linking in with other bits and smooth pathways between what we are doing and they don’t easily work across what I would call boundaries you know” (Site E, p84).</p> <p>3b) The evolution of intermediate care from individual services into a wider framework of provision presented a significant challenge to the roles and expertise of the frontline staff and was perceived to be threatening: “Maybe there is more liaison between the different branches but I still feel we are under some pressure to be able to do everything and I feel that we have been in separate teams previously and I think that we can’t do everything for everyone and we can’t keep all the balls in the air....” (Site E, p84).</p> <p>3c) Knowledge about the range of services available and their eligibility criteria varied among IC staff “..... there are boundaries between the intermediate care teams and sometimes we don’t quite understand what the criteria would be for somebody being seen by another team” (Site A, p84).</p> <p>3d) Lack of co-location, management by separate organisations (typically PCTs and social services) and operating across large rural areas identified as some of the practical barriers</p>	

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		<p>to closer collaboration between services - a general lack of strategic planning in intermediate care: "We haven't really taken a thorough stock-take of what do we really need and shape services from that. It has been a case of, we have got some money to do this and well let's do this and we are about to plan a complete review of our services and think about what we need" (Site D, p84).</p> <p>4. Stakeholder involvement in the planning and delivery of intermediate care.</p> <p>4a) Membership of these forums varied greatly. It was felt that involvement by clinicians, the independent sector, the voluntary sector and housing organisations was essential in order to bolster capacity within intermediate care and promote its use. Acute clinicians had felt excluded from the development and provision of intermediate care to some degree, and GP engagement had proved difficult. Marginalisation of clinicians and practitioners meant that the development of intermediate care had been managerially dominated in some cases, and proposed service developments not always perceived to have been practical or patient-centred: "I think that's only natural that it would be because they're [managers] not out in the field working, and their [priorities] are not client driven and client centred ..... they need to tick</p>	

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		<p>their boxes for the government, they need to be financially driven, they have different pressures on their agenda than we do..." (Site D, p85).</p> <p>4b) The involvement of the independent sector: barriers in the form of costs and insufficient capacity presented challenges to greater collaboration: "Yes I think they do have a role and part of that whole system model... I think they are being constrained currently by legislation and things like the care standards... [there's] this constant battle around costs and funding that maybe constrains some of the more proactive work about doing things differently and developing new ways of providing services" (Site A).</p> <p>4c) The involvement of the voluntary sector in providing transport, befriending and sitting services: some IC staff had reservations about the ability of voluntary sector providers to be more directly involved in service delivery, particularly considering other demands upon their resources such as having secure funding in facilitating this: "So we are doing quite a lot of work at the moment in trying to involve the voluntary sector in particular more in what we do because they can take a tremendous amount of pressure off us. The bit that I don't think, both health and social services haven't done effectively yet is funded them.... talking about at</p>	

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		<p>least 3 years type funding so they know they have got security because otherwise they can't offer it. A year funding doesn't work for these organisations" (Site E, p86).</p> <p>4d) The involvement of housing associations and local authority housing departments in providing sheltered housing environments for IC: the lack of dedicated staff to support people in such environments (particularly at night) was a significant barrier to use, many staff challenged the very concept of delivering intermediate care in a non-home setting: "I don't agree with taking people out of their home environments.... [to] put [them] into a strange flat and expected to rehabilitate and then go home and readjust to their home environment and to me that seems slightly odd" (Site D, p86). Sometime, such facilities being used inappropriately, to resolve accommodation issues rather than to deliver intermediate care.</p> <p>5. Service development and delivery issues.</p> <p>5a) 'Gaps' in intermediate care - a lack of provision for older people with mental health problems. Some attributed the problem to intermediate care 'cherry-picking' clients and the 6-week time limit that effectively excluded some people with mental health problems who could benefit from intermediate care. There was also a lack of specialist mental health input in</p>	

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		<p>intermediate care teams which was highlighted as the main barrier: “..because the intermediate care units don’t have a great deal of old age psychiatry support... and so many, many patients are excluded from going to intermediate care because they are confused and yet these actually were the patients who are most vulnerable for being in hospital .....” (Site B, p87).</p> <p>5b) gaps in provision due to geographical inequalities in terms of the coverage of and access to particular intermediate care services: “.....If you link service provision and choice with things like accessibility and local then that is a mismatch between what we had and what we need. So I think there are inequalities and perhaps still some vulnerable groups who might not have the same access....” (Site A, p87).</p> <p>5c) Imbalance between services aimed at admission avoidance and those which facilitated early supported discharge. Too much emphasis on the latter (ESD), should have more focus on prevention and community based intermediate care. Too reactive instead of proactive: “We are still reacting because it would be nice to even do more prevention, like falls groups in the community would prevent people, keep people going before they even fall in the first place.....” (Site D, p88).</p>	

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		<p>5d) In service delivery, 2 particular areas of weakness:</p> <p>i) the physical environment in which services were delivered - a shortage of office accommodation and storage space for equipment seen as problematic by many staff. The delivery of intermediate care services in non-purpose built environments (e.g. hospital wards, nursing/residential homes) presented particular challenges: “[The building] wasn’t designed with any rehabilitation space for either physiotherapists or ADL type facilities. ....we wouldn’t do any ADL OT specific kitchen focus work at the unit. We would concentrate on being able to assess and help people to re learn making cups of tea and using microwaves, and things that if you are going to live independently but with help coming in, you can probably manage” (Site B).</p> <p>ii) The challenges of delivering intermediate care in large, rural areas: time, distance and transport as issues which could impact on service responsiveness and efficiency: “..... there have been big recruitment issues because of house prices and cost of living [here] so we struggle to recruit. There are also rural transport issues as well so people actually can’t come into a central base....” (Site D, p88).</p> <p>6. Future priorities (reflected a need to address</p>	

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		<p>the weaknesses and barriers associated with intermediate care).</p> <p>a) Service expansion:</p> <p>i) Expansion of bed capacity within intermediate care to be established in a range of settings including, community hospitals, independent nursing and residential homes and the development or strengthening of non-residential intermediate care services.</p> <p>ii) Extend the operating hours of existing services to include evening and weekend cover.</p> <p>iii) Extend intermediate care to people with mental health problems (Additional CPN/mental health support worker input in intermediate care teams).</p> <p>b) Workforce development:</p> <p>i) Financial constraints and recruitment problems were identified as the main challenges to workforce development. The development of rotational placements, enabling workers to experience a number of different settings (acute, community, intermediate care) was suggested as an opportunity to raise the profile of intermediate care, increase awareness of other people's roles and help to furnish practitioners with the skills needed to deliver intermediate care.</p> <p>ii) To develop the workforce from 'within' - With appropriate support and supervision, junior</p>	

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		<p>practitioners could be nurtured to become the intermediate care workforce of the future.</p> <p>iii) To increase the number of support workers such as health care assistants and rehabilitation assistants- regular and on-going training for rehabilitation assistants together with open dialogue between professional and non-professional staff (p92).</p> <p>c) 'Whole-systems' working:</p> <p>i) The integration of health and social care organisations (typically PCTs and social services) - to assimilate individual intermediate care services into a single system and the promotion of access to intermediate care from mainstream care, for example, integration on various levels ranging from the use of pooled budgets and integrated provision to facilitate a more strategic approach to the future development of intermediate care particularly in the use of resources (both financial and human) and commissioning.</p> <p>ii) Actively promoting and reinforcing awareness of intermediate care services amongst mainstream practitioners, especially GPs, or that IC services would be 'attached' to primary health care teams or GP.</p> <p>iii) Make plans to establish new services in A&amp;E/Medical Assessment Units (MAU) in order to divert patients into intermediate care with the</p>	

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		<p>aim of preventing admission to mainstream care (e.g. social worker as part of the Assessment team at AE).</p> <p>vii) The creation of a single point of access (SPA) for intermediate care services.</p> <p>7. Future concerns:</p> <p>a) Funding for intermediate care - inadequate funding would place constraints upon planned future service developments, the lack of certainty regarding continuing and long-term investment in intermediate care.</p> <p>b) Workforce development - financial pressures and recruitment difficulties, an ongoing challenge. Need for a strategic approach to workforce development as uncertainty surrounding future funding, together with a lack of a 'whole-systems' approach to workforce development were key obstacles.</p> <p>c) Future policy development - An increased emphasis upon admission avoidance schemes and community based intermediate care in official policy statements. The need to extend the six-week time limit as this was considered too short a period in which to fully rehabilitate frail older people. Also to consider the need for a national campaign to raise public awareness of intermediate care. Patient satisfaction survey (843 questionnaires/1470 returned-response rate 57%)(max score =5) (I interpret the items of</p>	

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		<p>the questionnaire to be some components of care experienced positively by IC users-Irene):</p> <ol style="list-style-type: none"> <li>1. Start of my care was very efficient (mean score 4.41).</li> <li>2. Team were careful to check everything at the start of my care (mean score 4.35).</li> <li>3. Team gave all the information I wanted about my condition (mean score 4.15).</li> <li>4. Team gave all the information I wanted about the care I was receiving (mean score 4.25).</li> <li>5. I had problems getting pain relief when I needed it (mean score 3.86).</li> <li>6. I had all the equipment necessary to care for me (mean score 4.28).</li> <li>7. The team did their best to help me become more independent (mean score 4.42).</li> <li>8. I felt able to talk to team about any problems or worries (mean score 4.33).</li> <li>9. The team always had time for me (mean score 4.39).</li> <li>10. I have been treated with kindness, respect &amp; dignity by the team (mean score 4.58).</li> <li>11. The team worked together and knew what each other was doing (mean score 4.24).</li> <li>12. I was well prepared for when the team finished providing care for me (mean score 4.10).</li> <li>13. The service finished providing care for me too early (mean score 3.85).</li> </ol>	

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		<p>14. The care I received after the team finished providing care for me was well coordinated (mean score 3.92).</p> <p>15. The team did everything that they could to make me well again (mean score 4.31).</p> <p>16. The care I received was just about perfect (mean score 4.20).</p> <p>17. There are some things team could have done better (mean score 3.81).</p> <p>18. I am happy with the amount of recovery I made while being cared for by the service (mean score 4.24).</p> <p>Levels of satisfaction were high, and comparable with other surveys of health service provision. The aspect of care with lowest scores was timing of discharge.</p>	

**7. Elbourne HF and le May A (2015) Crafting intermediate care: one team’s journey towards integration and innovation. Journal of Research in Nursing 20: 56-71**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<b>Study aim:</b> To evaluate the effectiveness of the PCIC (Person Centred Intermediate Care) model of	<b>Participants:</b> <ul style="list-style-type: none"> <li>Service users and their families, partners and carers - Service users being provided with Person Centred Intermediate Care in a nursing</li> </ul>	<b>Effect sizes –</b> Measures of central tendency and dispersion were calculated in analysing the quantitative data, and a one-tail paired-sample t-test applied to measurements taken using the Barthel Index (BI) 100 scores. Using BI 100 scores (the higher	<b>Overall assessment of internal validity:</b> + <b>Overall assessment of external validity:</b>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>Intermediate Treatment being used in a nursing home or Total Care Living Complex, by studying service user outcomes and staff team functioning during 12 months from the nursing home's first 2 years of operation.</p> <p><b>Methodology:</b> Mixed methods. This case study of IC in 1 nursing home used a mixed methods approach, concurrently collecting and triangulating quantitative and qualitative data on the impact that care received during the stay in the nursing had on outcomes for the service users.</p>	<p>home, as a way of reducing their time in hospital, either in order to avoid admission or through early discharge from hospital.</p> <ul style="list-style-type: none"> <li>• Professionals/practitioners - Staff providing care and other support services to service users, and key informants (CEO and senior managers).</li> </ul> <p><b>Sample characteristics</b></p> <ul style="list-style-type: none"> <li>• Age - Service users: not reported. Staff and key informants: not reported.</li> <li>• Sex - Service users: not reported. Staff and key informants: not reported.</li> <li>• Ethnicity - Service users: not reported. Staff and key informants: not reported.</li> <li>• Religion/belief - Service users: not reported. Staff and key informants: not reported.</li> <li>• Disability - Service users: not reported. Staff and key informants: not reported.</li> <li>• Long term health condition -</li> </ul>	<p>the score, the greater the likelihood of being able to manage at home) service users were assessed on admission with scores of minimum 3 and maximum 88, mean (DS) 53.95 (19.1), and on discharge minimum 28, maximum 100, mean (SD) 78.2 (14.2). Change in BI 100 scores was: minimum score -28, maximum score 76, mean (SD) 24.3 (19.6), correlation 0.350, p&lt;0.001. 64 service users had a marked improvement in their level of functioning, 5 had a reduced level, and 4 had no change in their BI 100 scores, with their scores of 64, 84, 85 and 85 remaining the same. One service user died, and 9 were transferred back to hospital.</p> <p><b>Narrative findings – effectiveness</b> Outcomes for service users: - Functioning: Measured using the Barthel Index 100, where higher scores indicate an increased capacity to function independently, service users generally showed an improved score at the end of their stay, with the mean score rising from 53.95 to 78.2, and 64 participants showing a 'marked improvement in their level of functioning' (p63), with 4 remaining level, and only 5 a reduced level, although there are a further 10 service users who were not given a score but where it may be presumed to have decreased, as 9 returned to hospital and 1 died.</p>	+

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>Quantitative data was collected which measured the service users' ability to manage the tasks of daily living at the beginning and end of their stay. Qualitative data was collected using semi-structured interviews with service users and with staff and key informants. The study also states that it analysed documents related to the unit's development, and routinely collected activity data held within the facility about each service user, but the findings from these data sources are not presented.</p> <p><b>Country:</b> UK.</p>	<p>Service users: not reported. Staff and key informants: not reported.</p> <ul style="list-style-type: none"> <li>• Sexual orientation - Service users: not reported. Staff and key informants: not reported.</li> <li>• Socioeconomic position - Service users: not reported. Staff and key informants: not reported.</li> </ul> <p><b>Sample size</b></p> <ul style="list-style-type: none"> <li>• Intervention number - 168 service users were admitted to the unit for Intermediate Care during the 12 month period of the study, and after screening 94 of them were considered eligible to take part in the study.</li> <li>• 94 service users receiving Person Centred Intermediate Care in a nursing home were interviewed, the change in the Barthel Index 100 scores of 74 service users were measured, and 59 service user satisfaction questionnaires were completed. There were</li> </ul>	<p>- Destination: The study states that 74.1% of service user participants were discharged to their own homes. It does not provide data about post-PCIC destination for the remainder, although the report does state the 9 service users returned to hospital and 1 died in the nursing home.</p> <p><b>Narrative findings - qual and v&amp;e</b> 91.6% of service users stated that they were satisfied with the amount of recovery they made during their stay, 96.5% felt they became more independent, and 96.7% believed the team treated them with kindness, dignity and respect. A Balanced Scorecard diagram indicates that around 90% rated as good or excellent the PCIC unit's performance in terms of 'Value for money - the service received adapted to meet my needs and preferences', but no precise data or further information is provided. Several issues with the way the staff group was functioning emerged from their interviews, due in their view to: Inappropriate referrals from local transferring hospitals, who had not been educated about the services and resources the unit provided; - Inadequate information for staff group about the theoretical model they were working to and the responsibilities of multi-disciplinary team (MDT) members.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Source of funding:</b> Not reported. Report states that the 'research received no specific grant from any funding agency in the public, commercial, or not-for profit sectors' (p70).</p>	<p>interviews with 12 staff providing care and other support services to service users, and 4 key informants who were the lead charity's CEO and 3 senior managers</p> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Intermediate care (bed-based, using Person Centred Intermediate Care (PCIC) model in a nursing home/Total Care Living Complex).</li> <li>• Describe intervention - Explores the impact of PCIC on service users who were either being discharged early from hospital (step-down care) or from the community to prevent hospital admission (step-up care) within a community-based nursing home/intermediate care unit. Services were delivered on the basis that care-givers should appreciate service users' need for privacy and respect their dignity and freedom of choice</li> </ul>	<ul style="list-style-type: none"> <li>- Factionalism within the team.</li> <li>- Clashes of ideologies, e.g. between encouraging service users to participate in rehabilitation and respecting a choice not to participate.</li> <li>- Incompatibility between the regulator CSCI's requirements of the unit as a registered nursing home and their functioning as an Intermediate Care unit.</li> <li>- Concern that instability, arising from the departure of 2 out of 4 key members of the initial staff group, was leading to the initial vision, aims and goals of the unit being lost.</li> <li>- A concern that professional power struggles were leading to professional judgements being ignored.</li> <li>- A perception that autocratic leadership was manipulating the MDT meetings. However service users perceived the team as being highly effective at improving their functional abilities, and 88% of service users believed the team worked well together. It appears that practitioner dissatisfaction did not impact significantly on the service users' experience of the care and support services they provided.</li> </ul>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>in all circumstances.</p> <ul style="list-style-type: none"> <li>• Delivered by - Nurses, health care and rehabilitation assistants, physiotherapists, occupational therapists, and social workers from public sector health and social care providers and a local charity. A Senior House Officer was present for 2 full and 2 half days per week, as part of a vocational training scheme for GPs.</li> <li>• Delivered to - Service users who were either being discharged early from hospital (80% of sample) or being supported to prevent admission to hospital (20% of sample). 56.3% of participants had a history of falls, and 63.8% had 3 or more pre-existing ailments.</li> <li>• Duration, frequency, intensity, etc. - Service users stayed in PCIC unit for between 1 and 105 days. Frequency and intensity of intervention provided according to needs</li> </ul>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>and wishes of service user, but care was provided on a 24 hour basis.</p> <ul style="list-style-type: none"> <li>• Key components and objectives of intervention - The objective of the intervention was to reduce the time that service users spend in hospital by delivering Intermediate Care to them in a residential nursing home. The study assessed the effectiveness of delivering IC through person centred care, i.e. where staff respected service users' privacy and freedom of choice. Effectiveness was measured both in terms of service users' satisfaction and outcomes ratings, and in terms of the staff group's own perceptions of how the staff group functioned during the period studied and factors which they believed had an impact on their effectiveness in providing care and support services.</li> <li>• Location/place of delivery - The service was delivered</li> </ul>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>within a recently opened nursing home which was a purpose built unit within a Total Care Living Complex. The complex 'provided a variety of living arrangements for older people ranging from independent to warden-assisted housing, to rehabilitative care within the PCIC unit' (p58-9), enabling service users to be supported with care appropriate to their needs, and for the level of support to be changed as their needs changed.</p> <p><b>Comparison:</b> Service users' performance in acts of daily living was measured using the Barthel Index, at the points when they entered and when they left the unit. Service users also participated in semi-structured interviews. On admission they discussed what they needed from the service, and on discharge discussed whether the service met their expectations. They also</p>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>completed a service user satisfaction questionnaire. Staff and key informants participated in a series of semi-structured interviews, where they discussed emerging themes about their functioning as a staff group.</p> <p><b>Outcomes measured</b></p> <ul style="list-style-type: none"> <li>• Service user related outcomes <ul style="list-style-type: none"> <li>- Outcomes that were measured for service users included length of stay in the nursing home, whether they left the unit to go home or return to hospital, and whether their mobility and self-care improved or not while they were in the unit.</li> </ul> </li> <li>• Family or caregiver related outcomes - not reported.</li> <li>• Satisfaction with services - Service users' satisfaction with services is reported in terms of how satisfied they were with the amount of recovery they made during their stay, whether they felt they became more independent, and</li> </ul>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	<p>whether they felt the team treated them with kindness, dignity and respect.</p> <ul style="list-style-type: none"> <li>• Service outcomes - The service was measured in terms of the self-perceived functioning of the team of practitioners, and checked for correlation with service users' satisfaction with the services they provided.</li> </ul> <p><b>Follow-up:</b> Service users were assessed using the Barthel Index 100 and interviewed when they arrived in the nursing home and when they left. The time between these dates ranged from one-105 days.</p> <p><b>Costs?</b> No. A Balanced Scorecard Diagram, illustrating service user satisfaction, shows that around 90% of service users rated the service good or excellent in terms of 'Value for money - the service received adapted to meet my needs and preferences', but the report provides no additional</p>		

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
	information.		

**8. Nancarrow SA, Booth A, Ariss S et al. (2013) Ten principles of good interdisciplinary team work. Human Resources for Health 11**

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p><b>Study aim:</b> The aim of the research was to identify the key characteristics of interdisciplinary team working with a particular (although not exclusive) focus on community rehabilitation and intermediate care services (CRAICS).</p> <p><b>Methodology:</b> Qualitative study. Facilitated discussions with IC teams based on evidence from a systematic review about the key</p>	<p><b>Participants:</b> Professionals/practitioners - IC team members.</p> <p><b>Sample characteristics</b></p> <ul style="list-style-type: none"> <li>• Age - Not reported.</li> <li>• Sex - Not reported.</li> <li>• Ethnicity - Not reported.</li> <li>• Religion/belief - Not reported</li> <li>• Disability - Not reported.</li> <li>• Long term health condition - Not reported.</li> <li>• Sexual orientation - Not reported.</li> <li>• Socioeconomic position - Not reported.</li> </ul> <p><b>Sample size:</b> 11 CRAICS including 253 staff were recruited to participate in a related study to</p>	<p><b>Narrative findings - qual and v&amp;e</b></p> <p>These are the findings from the facilitated workshops. They are the characteristics, which IC team members believed to be associated with a 'good team'.</p> <ol style="list-style-type: none"> <li>1. Good communication - referring to intra-team communication. Team members need to feel as though communication is 2 way. They need to be able to listen as well as be able to speak out. Being a part of a large team seems to make communication more difficult.</li> <li>2. Respecting/ understanding roles - the importance of respecting and understanding the roles of other team members, including the boundaries of each role.</li> <li>3. Appropriate skill mix - teams value diversity and they need input from a range of staff with complementary skills and experiences.</li> <li>4. Quality and outcomes of care - ensuring quality and outcomes of care is an important component of a good team. It's therefore</li> </ol>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> +</p>

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
<p>characteristics of effective interdisciplinary working. Participating staff were recruited to participate in a related study to exam the impact of implementing an Interdisciplinary Management Tool (IMT). As part of this research, staff attended facilitated workshops and one of the outcomes of the workshops was a report of their views about what they considered to be the characteristics of a 'good team'.</p> <p><b>Country:</b> UK.</p> <p><b>Source of funding</b> Government: NIHR Health Services and</p>	<p>exam the impact of implementing an Interdisciplinary Management Tool (IMT). We can only assume that all 253 staff contributed to the report although no concrete information is provided.</p> <p><b>Intervention:</b></p> <ul style="list-style-type: none"> <li>• Intervention category - Intermediate care (NOT including reablement).</li> <li>• Description - Community based services offering care for older people to prevent admissions and facilitate discharge from acute care.</li> <li>• Delivered by - We are told only that CRAICs typically employ at least 4 different staff types including nurses, physiotherapists and occupational therapists. Support workers also play an important role.</li> <li>• Delivered to - Older people who meet the eligibility criteria (details not provided).</li> </ul>	<p>important to have systems for capturing patient outcomes. Emphasized the importance of setting targets, defining outcomes, following up patients and providing feedback to other services e.g. about appropriateness of referrals.</p> <p>5. Appropriate team processes and resources - staff need to have time and space to be able to make sensitive phone calls in privacy and appropriate procedures and systems are needed e.g. induction processes, policies, paperwork. The patient's pathway and the integration of the team with wider services are also seen as important procedural issues.</p> <p>6. Clear vision - important for establishing appropriate referral criteria into the team.</p> <p>7. Flexibility - described as an important individual attribute so that team members can respond to people's constantly changing needs. The service also needs to be flexible, in terms of eligibility criteria.</p> <p>8. Leadership and management - importance of a good leader was cited by all teams.</p> <p>9. Team culture, camaraderie and team support - the importance of team culture was the largest theme. Trust, reliability, commitment and support were the most commonly raised themes.</p> <p>10. Training and development opportunities - continuing professional development.</p>	

Research aims	PICO (population, intervention, comparison, outcomes)	Findings	Overall validity rating
Delivery Research program.	<ul style="list-style-type: none"> <li>• Duration, frequency, intensity, etc. - Not reported.</li> <li>• Key components and objectives of intervention - Not reported.</li> <li>• Content/session titles - Not reported.</li> <li>• Location/place of delivery - Not reported.</li> <li>• Describe comparison intervention - Not reported.</li> </ul> <p><b>Outcomes measured</b></p> <ul style="list-style-type: none"> <li>• Service user related outcomes - Not measured.</li> <li>• Family or caregiver related outcomes - Not measured.</li> <li>• Satisfaction with services - Not measured.</li> <li>• Service outcomes - Not measured</li> </ul> <p><b>Follow-up:</b> No follow-up.</p> <p><b>Costs?</b> No.</p>	<p>11. External image of the service - included external marketing, which is important for managing referrals and the workload of the team.</p> <p>12. Personal attributes - e.g. approachability, ability to compromise, empathy, confidentiality, patience, personal responsibility etc.</p> <p>13. Individual rewards and opportunities - individual returns have a positive impact on teamwork. Note that the findings from the document review have not been extracted because this element of the work focussed on interdisciplinary team working in a general sense. It did not have a specific focus upon intermediate care.</p>	

## Question 7 – Critical appraisal – Effectiveness

1. Ariss S, Enderby P, Smith T et al. (2015) Secondary analysis and literature review of community rehabilitation and intermediate care: an information resource. Southampton: National Institute for Health Research

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> This review relates to 4 questions, 1 of which matches our review question - To examine the effectiveness of different models of intermediate care, i.e. What team-level factors are associated with the greatest benefits for patients in terms of health status?</p> <p><b>Methodology:</b> Systematic review. From the findings of the systematic review, secondary analysis of the relationship between structural team-level variables and patient outcomes were conducted.</p> <p><b>Country:</b> UK.</p>	<p><b>Appropriate and clearly focused question?</b> Yes. To examine the effectiveness of different models of intermediate care: What team-level factors are associated with the greatest benefits for patients in terms of health status?</p> <p><b>Inclusion of relevant individual studies?</b> Somewhat relevant. Two included studies were not specifically IC but were related to 'good quality care' and community care of patients with COPD and CHF.</p> <p><b>Rigorous literature search?</b> Yes. Two different literature searches conducted of studies published between 2008 and 2012. Search strategy available.</p>	<p><b>Does the study's research question match the review question?</b> Yes. This review relates to 4 questions, 1 of which match our review question.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. Received ethics and research governance approval from relevant institutions.</p> <p><b>Were service users involved in the design of the study?</b> Not reported.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. One of the objectives focuses on our review question: to examine the effectiveness of different models of intermediate care.</p>	<p><b>Overall assessment of internal validity:</b> -</p> <p><b>Overall assessment of external validity:</b> ++</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Study quality assessed and reported?</b> Unclear.</p> <p><b>Adequate description of methodology?</b> No. No information on quality assessment of studies, scant information on characteristics and details of included studies such as sample size, study designs.</p> <p><b>Do conclusions match findings?</b> Partly.</p>	<p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. People who use IC services.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. IC setting.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. IC&amp;R.</p> <p><b>Are the study outcomes relevant to the guideline?</b> Yes. Patients' health status.</p> <p><b>Was the study conducted in the UK?</b> Yes.</p>	

**2. Smith T, Harrop D, Enderby P et al. (2013) Exploring differences between different intermediate care configurations: a review of the literature. Sheffield: Sheffield Hallam University, University of Sheffield**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<b>Study aim:</b> To explore the relationship between different	<b>Appropriate and clearly focused question?</b> Yes. To	<b>Does the study's research question match the review</b>	<b>Overall assessment of internal validity:</b>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>team characteristics and patient outcomes in intermediate care.</p> <p><b>Methodology:</b> Systematic review (Lit review, not SR).</p> <p><b>Country:</b> Range of countries.</p>	<p>explore the association between team characteristics and outcomes of IC.</p> <p><b>Inclusion of relevant individual studies?</b> Somewhat relevant. At least 5 of the studies evaluate interventions that would not be included according to the review protocol for Q7 e.g. 'primary care teams' and single condition rehab.</p> <p><b>Rigorous literature search?</b> Partly rigorous. 20 databases were searched using a clear, systematic search strategy and inclusion criteria, which is positive. However, there is no reporting of any technical testing of search terms or the development of a technical strategy. In addition to the 20 databases, the literature search could have benefitted from citation searching and reference harvesting, author checking and searching current trials, plus searching</p>	<p><b>question?</b> Yes. Exploring the association between team IC team characteristics and outcomes.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Not reported.</p> <p><b>Were service users involved in the design of the study?</b> No</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. Intermediate care.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. Older people using IC.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. The included studies evaluated</p>	<p>+</p> <p><b>Overall assessment of external validity:</b> ++</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>for grey sources of literature and organisational knowledge.</p> <p><b>Study quality assessed and reported?</b> No. This is a significant weakness of the review; the authors do not report any critical appraisal of the included studies.</p> <p><b>Adequate description of methodology?</b> Yes. Databases, inclusion criteria and screening on title, abstract and full text are clearly described.</p> <p><b>Do conclusions match findings?</b> Partly. The conclusions are rather brief and lacking in substance but this reflects the nature of the findings from the review. The included studies covered a range of interventions - not all fitting our IC definition - and very few addressed team level factors in relation to IC so it is unsurprising that the authors could not make strong</p>	<p>interventions in people's own homes or in specialist IC beds.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. Intermediate care - mainly home based. Not reablement.</p> <p><b>Are the study outcomes relevant to the guideline?</b> Yes. Service level and individual outcomes.</p> <p><b>Are the views and experiences reported relevant to the guideline?</b> Yes. Some included studies report the views of IC practitioners.</p> <p><b>Was the study conducted in the UK?</b> Yes. But included international studies.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	conclusions. The conclusions that are presented are a little overstated given that many of the team characteristics supposedly associated with improved care are only supported by 1 study and often that study does not fit the 'IC' definition. It is also difficult to judge the authors' conclusions about the associations between team characteristics and outcomes when there is no assessment of the quality of the included studies.		

### Review question 7 – Critical appraisal – the views and experiences of people using services, their families and carers

#### 3. Dixon S, Nancarrow SA, Enderby PM et al. (2015) Assessing patient preferences for the delivery of different community-based models of care using a discrete choice experiment. Health Expectations 18: 1204–14

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<b>Study aim:</b> The aim is 'to assess patient preferences for different models of care defined by location of care, frequency of care and principal carer within community-based health-	<b>Measures for contacting non-responders?</b> There is no mention of non-responders.  <b>Describes what was measured, how it was</b>	<b>Does the study's research question match the review question?</b> Yes. Question 7(b).	<b>Overall assessment of internal validity:</b> +  <b>Overall assessment of external validity:</b>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>care services for older people' (p1204).</p> <p><b>Methodology:</b> Surveys. Using the Discrete Choice Experiment approach, a quantitative survey was administered via interviews.</p> <p><b>Country:</b> Unidentified large city within the United Kingdom.</p> <p><b>Objectives of the study clearly stated?</b> Yes. 'To assess patient preferences for different models of care defined by location of care, frequency of care and principal carer within community-based health-care services for older people' (p1204).</p> <p><b>Research design clearly specified and appropriate?</b> Yes. The survey finds out hypothetical choices by using a DCE, collecting data using interviews. Using interviews rather than questionnaires would be an effective way to</p>	<p><b>measured and the results?</b> Yes. The measurements are of service users' chosen care preferences. The other measurements presented are the participants' Therapy Outcome Measured Scale (TOMS), which is described as 'a therapist-measured outcome measure' (p1207), and EQ-5D, a quality of life measure based on service user responses to 5 questions with 3 possible responses each. A table showing participants' care preferences according to these 2 measures is presented in the report.</p> <p><b>Measurements valid?</b> Yes. No reason to doubt the validity of the measurements.</p> <p><b>Measurements reliable?</b> Yes. No reason to doubt the reliability of the measurements.</p>	<p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. It is stated that the local research ethics committee provided ethical approval, and an ethics approval number is provided. However it is not explicitly stated that this is a health service approval. Details of ethical considerations are provided: 'equity of participation, the risks of respondent burden and/or distress, maintaining participant confidentiality, and the consideration of the trade-off of the risks versus the benefits to the participants' (p1207).</p> <p><b>Were service users involved in the study?</b> No. There is no statement in the study that would indicate service users were involved in its design.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes.</p>	<p>++</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>maximise participation, and to ensure questions and choices were properly understood by participants, since they could check their understanding with the interviewers - it is reported that 26% of the sample found the questions to be 'hard', and 20% found them to be 'not sensible'.</p> <p><b>Clear description of context?</b> Yes. The context is an Intermediate Care Service being provided by 1 of 6 teams within a large UK city.</p> <p><b>References made to original work if existing tool used?</b> N/A. The DCE questionnaire used was devised specifically for this study, so no use was made of an existing tool.</p> <p><b>Reliability and validity of new tool reported?</b> Yes. The process of designing the new tool and carrying out the interviews is described, including checking with</p>	<p><b>Measurements reproducible?</b> Yes. There is transparency about the process and the measures used, and it would be possible to reproduce the measurements.</p> <p><b>Basic data adequately described?</b> Yes. There is adequate description of the basic data.</p> <p><b>Results presented clearly, objectively &amp; in enough detail for readers to make personal judgements?</b> Yes. There is no evidence of bias in the presentation of the data. There is plenty of details to allow readers to make personal judgements about the meaning of the findings.</p> <p><b>Results internally consistent?</b> Yes There are no apparent contradictions in the findings presented.</p>	<p>Intermediate care is the sole focus of this study.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. The study population is older people being provided with home-based Intermediate Care following discharge from hospital.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. Participants in the study were living in a community setting, i.e. their own home.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. By soliciting the views of service users being provided with Intermediate Care, the study contributes towards assessment for planning of person centred Intermediate</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>respondents that they understood the experiment, and whether they felt anything important had been missed. There is no reason to doubt the reliability or validity of the new tool.</p> <p><b>Survey population and sample frame clearly described?</b> Yes. Older service users, recently discharged from hospital, who were being provided with an Intermediate Care service at home.</p> <p><b>Representativeness of sample is described?</b> Yes. The study describes the representativeness, and limitations of this, in that the sample comprises all the service users they could recruit from just a single location, but is said to incorporate a spread of needs and health issues.</p> <p><b>Subject of study represents full spectrum of population of interest?</b> Partly. The</p>	<p><b>Data suitable for analysis?</b> Yes. The data consisted of responses to 3 very straightforward, multiple choice questions, measured against 2 other measures of participants' functioning and quality of life. It is very suitable for analysis.</p> <p><b>Clear description of data collection methods and analysis?</b> Yes. Data was collected by asking multiple choice question in an interview. The analysis method is clearly described.</p> <p><b>Methods appropriate for the data?</b> Yes. Analysis method is suitable for the data.</p> <p><b>Statistics correctly performed and interpreted?</b> Yes. Statistical analysis carried out using STATA statistical software.</p> <p><b>Response rate calculation provided?</b> No. No mention is</p>	<p>Care and Reablement, identifying needs and aspirations, within the social context of a service being provided at home.</p> <p><b>Are the views and experiences reported relevant to the guideline?</b> Yes. The study reports views but not experiences. The views presented are all concerned with preferences for the delivery of Intermediate Care from those receiving the service.</p> <p><b>Does the study have a UK perspective?</b> Yes. The study was carried out in a large but unidentified city within the UK.</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>representativeness of the sample is limited: it includes only older IC service users, they are all urban dwellers, all from 1 team out of 6 in the city where the DCE was carried out, and being provided with IC to promote early hospital discharge and not to prevent admission. The study acknowledges that 'this will not produce generalizable findings beyond the city or even the team' (p1213), although the service users included are described as representing a wide range in terms of their care needs and health. The study also failed to recruit their target number of participants, achieving only 77 instead of the 200 aimed for, so it is less representative than the researchers hoped for.</p> <p><b>Study large enough to achieve its objectives, sample size estimates performed?</b> Partly. The study aimed to recruit 200</p>	<p>made of response rate, i.e. whether any service users who could potentially have participated in the study refused to do so. Nor does the study state how many potential participants were ruled out as unsuitable by the researchers, either because they could not communicate in English or had severe cognitive impairment.</p> <p><b>Methods for handling missing data described?</b> Unclear. The study reports on the missing data rate, i.e. 31 out of a possible 616 responses (5%) were given the code 'don't know', which covers all reasons for no choice being made. The report does not explain how they were factored into the calculations.</p> <p><b>Difference between non-respondents and respondents described?</b> No.</p>		

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>participants, but achieved only 77. The researchers acknowledge that this had an impact on the power of the study to detect relationships within the data, but they still describe it as being 'one of the largest con joint analysis studies in the field' (p1211).</p> <p><b>All subjects accounted for?</b> Unclear. The study does not state whether anybody who was recruited dropped out.</p> <p><b>All appropriate outcomes considered?</b> Partly. The regression analysis showing the links between service users' IC preferences and their TOMS and EQ-5D ratings are presented in full. However, the table presenting the rankings of the different types of care package in order presents only 9 out of the 64 possible combinations, and does not give their reason for selecting those 9 and omitting the others.</p>	<p>No mention is made of non-respondents.</p> <p><b>Results discussed in relation to existing knowledge on subject and study objectives?</b> Yes. The study states that by identifying service user preferences with regard to Intermediate Care care package choices, it is adding to existing knowledge, and contributing to the aim of moving towards more patient centred care.</p> <p><b>Limitations of the study stated?</b> Yes. The researchers present all the limitations of the study in the report: not being generalisable due to geographic limitations, including only older participants, only hospital leavers, only those receiving care at home, only English speakers, only those without severe cognitive impairment.</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Response rate:</b> All 77 service users responded to at least 1 set of choices, and there were only 31 codings of 'don't know' from 616 possible choices, where 'don't know' covered any reason for not making a choice.</p>	<p><b>Results can be generalised?</b> No. Researchers are very clear that since this was effectively a case study of 1 area within 1 city, the findings cannot be generalised.</p> <p><b>Appropriate attempts made to establish 'reliability' and 'validity' of analysis?</b> Yes. Researchers used interviews to ensure respondents understood the choices they were being asked to make, and interviewers clarified any questions that arose, with this being recorded. Participants were asked 2 questions after the experiment interview, i.e. whether they found the questions 'hard' and whether they found them 'sensible'. The researchers also produced 2 versions of the interview questionnaire, which were randomly assigned to the study participants.</p> <p><b>Conclusions justified?</b> Yes. The researchers recognise the</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>study's limitations, and do not draw more conclusions from the data than is warranted. They recognise also the impact on the strength of the findings of not achieving their target number of interviews, and do not try to overstate the significance of their findings. The conclusions that they do draw are justified by the data.</p>		

**4. Pearson M, Hunt H, Cooper C et al. (2015) Providing effective and preferred care closer to home: a realist review of intermediate care. Health & social care in the community 23: 577–93**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b> The aim of the study was to explore what factors need to be taken into account, in terms of service users, practitioners and organisations, when local Intermediate Care services are being designed and delivered.</p> <p><b>Methodology:</b> Systematic review. The study is a 'realist review', a particular form of</p>	<p><b>Appropriate and clearly focused question?</b> Unclear. The study makes clear statements about its aims and methods, but there is no clear statement of what the research question is.</p> <p><b>Inclusion of relevant individual studies?</b> Yes. All studies included in the review are relevant to the subject of good practice in person</p>	<p><b>Does the study's research question match the review question?</b> Yes. The study aims to provide information about the characteristics of Intermediate Care service delivery that will improve outcomes for service users and their families.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Not</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>systematic review which aims to use evidence to address the practical realities and challenges of public policy and practice.</p> <p><b>Country:</b> Various – although 33/38 of included studies were by UK authors.</p>	<p>centred Intermediate Care provision.</p> <p><b>Rigorous literature search?</b> Yes. The study used broad definitions to carry out database searches of Medline, Medline in process, Embase, Social Policy and Practice, HMIC, British Nursing Index, The Cochrane Library, Cinahl and Assia, as well as editorials, commentaries and grey literature reports.</p> <p><b>Study quality assessed and reported?</b> Partly reported. The review states that sources were critically appraised 'using the Wallace et al. (2004) tool for assessing the quality of applied social policy research', but it provides no details of how this process was carried out.</p> <p><b>Adequate description of methodology?</b> Partly adequate. The study describes the process of database</p>	<p>reported. Ethical issues are not discussed, other than to state that none of the authors of the study have a conflict of interest.</p> <p><b>Were service users involved in the design of the study?</b> Not reported. Description of methodology makes no mention of service user involvement in the design of the study.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. This is specifically a study aimed at making proposals for best practice in the provision of Intermediate Care services.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. The service users in the studies covered by this realist review are all being provided with Intermediate Care.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>searches, and the input from the Project Reference Group into developing programme theories that informed the development of the review's conceptual framework, with a diagram illustrating the conceptual framework. Details of how the realist approach was applied are not included in the main study report, but in a supporting material file which was not part of the article.</p> <p><b>Do conclusions match findings?</b> Yes. There is no inconsistency between the reported findings and the discussion about the conclusions and recommendations.</p>	<p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. The setting where IC is being provided is not described for each of the studies covered by the review, but does include studies where IC was being provided at home, and where it was being provided in specialist units, e.g. for stroke victims.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. The study examines features of Intermediate Care service provision that can make the service person centred.</p> <p><b>Are the study outcomes relevant to the guideline?</b> Yes. The study makes recommendations on ways to make Intermediate Care services person centred.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
		<p><b>Are the views and experiences reported relevant to the guideline?</b>  Yes. In 29 out of the 38 studies included in the review, data was collected using individual or focus group interviews, either as the only method used or in conjunction with other data collection methods. The data they provide concern what are the features of Intermediate Care provision that can make it more successfully person centred.</p> <p><b>Was the study conducted in the UK?</b> Yes. The study was conducted by researchers based in the UK. 33/38 studies included in the review are UK studies.</p>	

**5. Wilson A, Richards S, and Camosso-Stefinovic J (2007) Older people's satisfaction with intermediate care: A systematic review. Reviews in Clinical Gerontology 17: 199–218**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<b>Study aim:</b> The aim of the review was to explore service	<b>Appropriate and clearly focused question?</b> No. The	<b>Does the study's research question match the review</b>	<b>Overall assessment of internal validity:</b>

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>user satisfaction of older people being provided with Intermediate Care.</p> <p><b>Methodology:</b> This is a systematic review of 31 studies dealing with user satisfaction of older people being provided with Intermediate Care.</p> <p><b>Country:</b> Range of countries. The review was carried out by academics from UK universities, but included 14/31 studies from non-UK countries (Australia 5, New Zealand 2, US 2, and Sweden, Spain, Norway, Thailand and Canada 1 each) with 1 country unspecified).</p>	<p>review does not provide a research question. It provides a statement of what it is: 'Older people's satisfaction with intermediate care: a systematic review'.</p> <p><b>Inclusion of relevant individual studies?</b> Somewhat relevant. A number of included studies are not relevant, as 14 of the deal with single condition rehabilitation.</p> <p><b>Rigorous literature search?</b> Yes. The review searched the MEDLINE, EMBASE, BNI, CINAHL and PsycINFO databases, using search terms described in the Cochrane Review search strategy and from several published papers which concerned Intermediate Care.</p> <p><b>Study quality assessed and reported?</b> No. No assessment of the quality of the included studies is reported.</p>	<p><b>question?</b> Partly. The study deals mainly with the level of satisfaction that service users have with Intermediate Care, and in 18 comparison studies how it compares with service users receiving 'usual care'. Although there is some data from case series and qualitative studies about what they consider to be important characteristics in providing satisfaction, little detail is provided.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Not reported. Ethical issues not discussed in the report.</p> <p><b>Were service users involved in the design of the study?</b> Not reported. There is no indication of service users having any involvement in the study's design.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The</p>	<p>-</p> <p><b>Overall assessment of external validity:</b></p> <p>+</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p><b>Adequate description of methodology?</b> Partly adequate. The report identifies the databases that were searched for relevant studies, but not the search terms that were used. The inclusion and exclusion criteria are presented. The results of the analysis of the included studies are presented in 4 tables.</p> <p><b>Do conclusions match findings?</b> Yes. The findings and the conclusions are consistent, i.e. that older people are generally more satisfied with Intermediate Care non-hospital care than with hospital or usual care, where these are alternative options for the same condition. The qualitative studies present some data on why this preference is expressed, and why in some cases it might not be preferred. The study presents references for 2 SRs,</p>	<p>focus of the study is Intermediate Care.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Partly. Although the study is of user satisfaction with Intermediate Care, 14 of the studies considered in the review dealt with single condition rehabilitation, which is outside the scope of the guideline.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. The studies reviewed concern people being provided with Intermediate Care in their own homes or in specialist units.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. The studies reviewed concern the effectiveness of Intermediate Care in terms of</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	but details of the findings of these SRs are not presented.	<p>service user satisfaction when it is being provided to people in their own homes or in specialist bed based units to avoid hospital admission or to facilitate early hospital discharge.</p> <p><b>Are the study outcomes relevant to the guideline?</b> Partly. In the studies where there was a control group, effectiveness was measured through a comparison between service users receiving Intermediate Care and those receiving usual care. In 13/18 comparison studies IC was measured as providing higher levels of service user satisfaction to an extent that was statistically significant. In the remainder there was not a significant difference. However, relevance to the guideline topic is limited, since 10 of these 18 studies fall outside the review protocol's 'intervention' criterion for</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
		<p>inclusion, as they deal with single condition rehabilitation.</p> <p><b>Are the views and experiences reported relevant to the guideline?</b>  Yes. In the case series and qualitative studies included in the review, factors influencing service users' preference for being provided with IC at home were identified. These included convenience and comfort, nearness to family, and more personalised care. However, service users with some conditions could feel safer in hospital, and 1 study reported that service users' main concerns were recovery and survival.</p> <p><b>Was the study conducted in the UK?</b> Yes. The SR was conducted by UK based academics, but included a range of countries (UK, US, Canada, Australia, New Zealand, Norway, Spain, Thailand).</p>	

## Review question 7 – Critical appraisal – Health, social care and other practitioners’ views and experiences

### 6. Barton P, Bryan S, Glasby J et al. (2006) A national evaluation of the costs and outcomes of intermediate care services for older people: final report. University of Birmingham: Health Services Management Centre

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Study aim:</b></p> <ol style="list-style-type: none"> <li>To establish the range, spread and speed of development of intermediate care services across England (data not relevant to review question).</li> <li>To explore the views of intermediate care leads on the benefits and challenges of implementing intermediate care policy.</li> <li>To assess the impact of intermediate care on the service system as a whole and on individual service users (p8).</li> </ol> <p><b>Methodology:</b> Mixed methods.</p> <ol style="list-style-type: none"> <li>Postal surveys (qualitative).</li> <li>Case studies (qualitative).</li> <li>Patient satisfaction survey.</li> </ol>	<p><b>Quantitative component:</b> Patient Satisfaction survey.</p> <p><b>Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed-methods question)?</b> Partly. Patient satisfaction survey: People who use IC at the 5 case study sites, no sampling.</p> <p><b>Is the sample representative of the population under study?</b> Yes. Case studies with quantitative data: IC staff at 5 case study sites. Patient satisfaction survey: People who use IC at the study sites.</p> <p><b>Are measurements appropriate (clear origin, or</b></p>	<p><b>Does the study’s research question match the review question?</b> Yes. Benefit and challenges of implementation if the IC system.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. Approved by the Trent MREC (Medical research ethics committee).</p> <p><b>Were service users involved in the study?</b> Yes. As participants.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. To explore the views of intermediate care leads on the benefits and challenges of</p>	<p><b>Overall assessment of internal validity:</b> +</p> <p><b>Overall assessment of external validity:</b> ++</p>

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>4. Qualitative focus: Views and experiences of IC managers, clinicians and people using IC.</p> <p><b>Country:</b> UK.</p> <p><b>Quantitative component:</b> Postal surveys.</p> <p><b>Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question?</b> Yes. Response to open questions of postal survey.</p> <p><b>Is the process for analysing qualitative data relevant to address the research question?</b> Yes.</p> <p><b>Is appropriate consideration given to how findings relate to the context, such as the setting, in which the data were collected?</b> Yes.</p>	<p><b>validity known, or standard instrument)?</b> Yes.</p> <p><b>Is there an acceptable response rate (60% or above)?</b> No. 57% response rate.</p> <p><b>Mixed methods component</b> <b>Is the mixed-methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed-methods question?</b> Yes.</p> <p><b>Is the integration of qualitative and quantitative data (or results) relevant to address the research question?</b> Yes.</p> <p><b>Is appropriate consideration given to the limitations associated with this integration, such as the divergence of qualitative</b></p>	<p>implementing intermediate care policy.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. Intermediate care co-ordinators, managers, frontline staff, and patients.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. All IC settings.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. All stages of IC.</p> <p><b>Are the study outcomes relevant to the guideline?</b> Partly. This report includes a systematic review on the impact of IC on service users (effectiveness). The included studies were all published before 2005, and effectiveness</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
Is appropriate consideration given to how findings relate to researchers' influence; for example, though their interactions with participants? Unclear.	and quantitative data (or results)? Yes.	is not within the scope of Question 7.  <b>Are the views and experiences reported relevant to the guideline?</b> Yes. Views of service users and practitioners.  <b>Does the study have a UK perspective?</b> Yes.	

**7. Elbourne HF and le May A (2015) Crafting intermediate care: one team's journey towards integration and innovation. Journal of Research in Nursing 20: 56-71**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<b>Study aim:</b> To evaluate the effectiveness of the PCIC (Person Centred Intermediate Care) model of Intermediate Treatment being used in a nursing home or Total Care Living Complex, by studying service user outcomes and staff team functioning during 12 months from the nursing home's first 2 years of operation.	<b>Quantitative component:</b> The research was a case study of all service users considered eligible to participate, after screening all admissions to a unit providing Intermediate Care over a 12 month period. Changes in their mobility and ability to manage activities of daily living during their period of residence in the unit were measured using the Barthel Index 100.	<b>Does the study's research question match the review question?</b> Partly. The study assesses the impact of 1 service model for delivering Intermediate Care to service users, i.e. person-centred care, but no mention is made of the impact on their families. The study gives a brief description of what makes this service model distinctive, with 1 quote from a service user	<b>Overall assessment of internal validity:</b> +  <b>Overall assessment of external validity:</b> +

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Methodology:</b> Mixed methods. This case study of IC in 1 nursing home used a mixed methods approach, concurrently collecting and triangulating quantitative and qualitative data on the impact that care received during the stay in the nursing had on outcomes for the service users. Quantitative data was collected which measured the service users' ability to manage the tasks of daily living at the beginning and end of their stay. Qualitative data was collected using semi-structured interviews with service users and with staff and key informants. The study also states that it analysed documents related to the unit's development, and routinely collected activity data held within the facility about each service user, but the findings from these data sources are not presented.</p> <p><b>Country:</b> UK.</p>	<p><b>Are participants (organisations) recruited in a way that minimises selection bias?</b> Partly. The study did screen all service users admitted to the unit for eligibility to participate in the research, meaning that participation was fairly wide. However although 55.9% of people admitted to the unit were considered eligible, there are no measures of improvements or decline in the functioning of those who did not meet the eligibility criteria. The experiences of non-English speakers is not measured, but information on how many were ruled ineligible on these grounds is not provided, nor on the outcomes for those unable or unwilling to express themselves verbally.</p> <p><b>Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between</b></p>	<p>describing why they appreciated the way they were treated, but it does not provide specific examples of what is meant by care being provided by 'people who appreciate their [service users'] need for privacy and respect their dignity and freedom of choice in all situations' (p57), so it is hard to assess which characteristics of this approach make it successful. Similarly, the study reports the high level of user satisfaction with this model, but there is no analysis of what components of the methods led to these high scores. The study also does not analyse what the practitioners thought were the important characteristics of the model, focusing only on what they thought of the way the unit and they as a staff group worked.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Qualitative component:</b> Semi-structured interviews with service users.</p> <p><b>Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question?</b> Yes. Interviews with the recipients of PCIC.</p> <p><b>Is the process for analysing qualitative data relevant to address the research question?</b> Unclear. The study states that 'inductive thematic analysis' was used to 'elicit core themes from the qualitative data' (p60), but the process of thematic analysis is not described.</p> <p><b>Is appropriate consideration given to how findings relate to the context, such as the setting, in which the data were collected?</b> Yes. Consideration of the context</p>	<p><b>groups when appropriate) regarding the exposure/intervention and outcomes?</b> Yes. The measurements are appropriate. They use the Barthel Index 100, an established measure regarded as reliable which brings together scores in 10 variables to measure people's mobility and performance in activities of daily living.</p> <p><b>In the groups being compared (exposed versus non-exposed; with intervention versus without; cases versus controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?</b> Yes. All participants in the study were being provided with the same model of Intermediate Care, and subject to the same eligibility criteria.</p> <p><b>Are there complete outcome data (80% or above), and,</b></p>	<p><b>Has the study dealt appropriately with any ethical concerns?</b> Partly. The study was given ethical approval by the Research Ethics Committee at the University of Southampton, and it states that all participants gave informed consent. It does not state whether this process involved gaining NHS approval, although several of the practitioners involved in meeting the services users' needs, and some who participated in the study, are health practitioners.</p> <p><b>Were service users involved in the study?</b> No. Service users provided quantitative data, but were not consulted on the research design and did not participate as researchers.</p> <p><b>Is there a clear focus on the guideline topic?</b> Yes. The focus of the study is the bed</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p>of the study, a PCIC unit located within a nursing home for older people, is present throughout the study.</p> <p><b>Is appropriate consideration given to how findings relate to researchers' influence; for example, though their interactions with participants?</b> No. The researchers' influence on the study is not discussed.</p> <p><b>Qualitative component:</b> Semi-structured interviews with practitioners delivering care and services to service users, and with key informants who were senior managers in the unit and the CEO of the charity organising the care and services being delivered.</p> <p><b>Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research</b></p>	<p><b>when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?</b> Partly. Outcome data is provided for 55.9% of those being provided with Intermediate Care in the unit during the study period, with the remainder deemed not to meet the eligibility criteria for inclusion in the study. Of those who did participate, interviews were carried out at admission and discharge with 94/94 (100%), changes in Barthel Index scores were recorded for 74/94 (82%), and questionnaires were completed by 59/95 (62%). Data on all the BI index outcome scores is provided, although detailed breakdown of individual components of the index is not provided.</p> <p><b>Quantitative Component:</b></p>	<p>based provision of a model of Intermediate Care to adults.</p> <p><b>Is the study population the same as at least one of the groups covered by the guideline?</b> Yes. The study population of this component is adults being provided with 1 model of intermediate care.</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Yes. The setting is a residential nursing home.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Yes. Key area 2: the study deals with the effectiveness of 1 model of Intermediate Care, i.e. bed based Intermediate Care in a nursing home to prevent premature admission to long-term residential care or hospital and support earlier discharge from hospital. The</p>	

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<p><b>question?</b> Yes. The source of data is semi-structured interviews with those with responsibility for directly delivering care and services or for organising delivery.</p> <p><b>Is the process for analysing qualitative data relevant to address the research question?</b> Unclear. The study states that 'inductive thematic analysis' was used to 'elicit core themes from the qualitative data' (p60), but the process of thematic analysis is not described.</p> <p><b>Is appropriate consideration given to how findings relate to the context, such as the setting, in which the data were collected?</b> Yes. The findings deal in part with how practitioners and key informants view the context, i.e. they present participants' views on certain matters affecting how the unit runs.</p>	<p>The study took the form of a case study using qualitative methods to measure the change in service users' mobility and ability to carry out everyday tasks independently between arriving at and leaving the unit.</p> <p><b>Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed-methods question)?</b> Yes. The sampling strategy was to screen all service users admitted to the nursing home to receive Person Centred Intermediate Care during a defined 12 month period for eligibility to participate in the study. Because the research was studying a particular approach to delivering Intermediate Care, it was appropriate to use the screening process to make the sample as inclusive as possible.</p>	<p>study also relates to reablement.</p> <p><b>Are the study outcomes relevant to the guideline?</b> Yes. The effectiveness of the approach to Intermediate Care in the unit is discussed. The study presents the views and of service users about the care and support services provided for them, but there is little detail about their experiences. The study presents the views and experiences of practitioners about the way the unit and they as a staff group work, but little about their views and experiences about bed based intermediate care.</p> <p><b>Are the views and experiences reported relevant to the guideline?</b> Yes. The views and experiences of the service users and of the practitioners are relevant to the guideline.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Is appropriate consideration given to how findings relate to researchers' influence; for example, though their interactions with participants?</b> No. The researchers' influence on the study is not discussed.</p> <p><b>Qualitative component:</b> Service users were invited to complete a service user satisfaction questionnaire, which yielded both quantitative and qualitative data.</p> <p><b>Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question?</b> Yes. The views of service users in how satisfied they were with the model of Intermediate Care provided to them is relevant to the research question.</p>	<p><b>Is the sample representative of the population under study?</b> Unclear. No information is provided which would enable an assessment of how representative the sample is, either of all service users admitted to the unit, or of the wider population of people being provided with Intermediate Care.</p> <p><b>Are measurements appropriate (clear origin, or validity known, or standard instrument)?</b> Yes. The measurements were carried out using the Barthel Index 100, which uses 10 variables to measure people's performance in acts of daily living and mobility. The purpose of Intermediate Care is to improve service users' ability to manage independently, making the BI an appropriate measure. The Barthel Index is considered to be reliable, although it does depend to an extent on</p>	<p><b>Does the study have a UK perspective?</b> Yes. The historical and policy background section of the study explains the UK context in which the study took place.</p>	

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Is the process for analysing qualitative data relevant to address the research question?</b> Unclear. The process of analysing data from the service user satisfaction questionnaire is not described.</p> <p><b>Is appropriate consideration given to how findings relate to the context, such as the setting, in which the data were collected?</b> Yes. Although the study does not provide details of the questions asked in the questionnaire, the satisfaction of service users with their experience of the provision of Intermediate Care within a nursing home is extremely relevant to the context in which the data was collected.</p> <p><b>Is appropriate consideration given to how findings relate to researchers' influence; for example, though their interactions with</b></p>	<p>consistency between those using it as a measurement tool.</p> <p><b>Is there an acceptable response rate (60% or above)?</b> Partly. 55.9% of potential participants in the study were considered to be eligible. Of those considered to be eligible, 74/95 (78%) were measured using the BI scale, while 59/95 (62%) completed the service users' satisfaction questionnaire.</p> <p><b><u>Quantitative Component:</u></b> Service users were invited to complete a service user satisfaction questionnaire, which yielded both quantitative and qualitative data.</p> <p><b>Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed-methods question)?</b> Yes. The sampling strategy was to screen all service users admitted to the</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>participants?</b> Unclear. Possible researchers' influence on the findings, e.g. through interaction with participants or help with completing questionnaires is not explored in the study.</p>	<p>nursing home to receive Person Centred Intermediate Care during a defined 12 month period for eligibility to participate in the study and to ask all those eligible to complete the service user satisfaction questionnaire.</p> <p><b>Is the sample representative of the population under study?</b> Unclear. The study does not provide data which would allow an assessment of how representative the sample is of the population under study.</p> <p><b>Are measurements appropriate (clear origin, or validity known, or standard instrument)?</b> No. Very little information is provided about what was asked in the questionnaire, and how the responses were measured.</p> <p><b>Is there an acceptable response rate (60% or above)?</b> Partly. 55.9% of potential participants were considered eligible to take part</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	<p>in the study, and of those considered eligible 62.1% completed the service user satisfaction questionnaire.</p> <p><b>Mixed methods component</b>  <b>Is the mixed-methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed-methods question?</b>  Yes. The study considered the effectiveness of 1 approach to providing Intermediate Care. The Barthel Index 100 provided quantitative data to measure the progress made by service users admitted to the unit. Interviews with service users and the service user satisfaction questionnaire provided qualitative, subjective data on the experiences of service users. Interviews with staff and key informants provided qualitative data on their</p>		

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	<p>perceptions of the functioning of the unit and the staff group.</p> <p><b>Is the integration of qualitative and quantitative data (or results) relevant to address the research question?</b> Partly. The objective measures of changes to service users' ability to manage independently and the service users' own subjective measure of their experience both address the question about what the outcomes are of using this model of Intermediate Care, but little information is provided about what are the characteristics of this particular model.</p> <p><b>Is appropriate consideration given to the limitations associated with this integration, such as the divergence of qualitative and quantitative data (or results)?</b> Partly. The study does not make a comparison of the data it presents on service users'</p>		

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
	improved functioning as measured using the Barthel Index 100 scale and the service users' satisfaction ratings. It does comment on the staff group and key informants' perception of the staff group as being dysfunctional and contrasts this with the service users' belief that the team was 'highly effective and worked well together' (p69), and offers the explanation that the staff put on a show of working well together in front of service users, despite their dissatisfactions.		

**8. Nancarrow SA, Booth A, Ariss S, et al. (2013) Ten principles of good interdisciplinary team work. Human Resources for Health 11**

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<b>Study aim:</b> The aim of the research was to identify the key characteristics of interdisciplinary team working with a particular (although not exclusive) focus on community rehabilitation and intermediate care services (CRAICS).	<b>Is the context clearly described?</b> Unclear. The characteristics of the participants of the workshops are not described - all we know is that they work in intermediate care teams which have implemented the	<b>Does the study's research question match the review question?</b> Partly. The systematic review element does not match our review question but the element that collated views of intermediate care teams did because it	<b>Overall assessment of internal validity:</b> +  <b>Overall assessment of external validity:</b> +

Internal validity - approach and sample	Internal validity - performance and analysis	External validity	Overall validity rating
<p><b>Methodology:</b> Qualitative study. Facilitated discussions with IC teams based on evidence from a systematic review about the key characteristics of effective interdisciplinary working. Participating staff were recruited to participate in a related study to exam the impact of implementing an Interdisciplinary Management Tool (IMT). As part of this research, staff attended facilitated workshops and 1 of the outcomes of the workshops was a report of their views about what they considered to be the characteristics of a 'good team'.</p> <p><b>Country:</b> UK.</p> <p><b>Is a qualitative approach appropriate?</b> Appropriate. The research question seeks to understand the views of intermediate care team members and the meanings</p>	<p>Interdisciplinary Management Tool. The workshops were informed by the systematic review of interdisciplinary team working and this introduces a risk of bias by influencing the views of participants about what constitutes a 'good team'. Data were only gathered during facilitated workshops and not for example through additional one to one interviews or during observations. One positive aspect is that the workshops were facilitated by external, trained facilitators so this reduces the risk of researcher bias.</p> <p><b>Was the sampling carried out in an appropriate way?</b> Inappropriate. As far as we can tell from the paper there was no sampling at all. The intermediate care workers were involved in the workshops because of their team's engagement in the IMT</p>	<p>sought data about the characteristics of a good intermediate care team.</p> <p><b>Has the study dealt appropriately with any ethical concerns?</b> Yes. With regard to the facilitated workshops: 'NHS ethics approval was obtained on 11 September 2008 (08/H1004/124). All participating team members provided written consent for their involvement in this research' (p4).</p> <p><b>Were service users involved in the study?</b> No. Neither as participants, advisors, nor co-researchers.</p> <p><b>Is there a clear focus on the guideline topic?</b> Partly. The systematic review work is not specifically relevant but the facilitated workshops are</p> <p><b>Is the study population the same as at least one of the</b></p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>they attach to the concept of a good team.</p> <p><b>Is the study clear in what it seeks to do?</b> Mixed. The purpose of the study is fairly well discussed in terms of aims/objectives and research question. However it is a little unclear why the systematic review is being used to develop a competency framework for intermediate care when this is not the specific focus of the SR, apart from the assertion that CRAICs 'exemplify the practice of interdisciplinary team work' (p3).</p> <p><b>How defensible/rigorous is the research design/methodology?</b> Somewhat defensible. The design is a little questionable, particularly the use of data derived from a systematic review about 'interdisciplinary team working' rather than intermediate care. The fact that the SR findings are then</p>	<p>intervention. The fact that they have been involved in the IMT intervention also risks bias because the intermediate care workers are likely to be particularly attuned to issues around interdisciplinary working, which will have influenced their perceptions of a 'good team'. It is possible that teams who had not been involved in the IMT intervention would have given different answers to those reported in this paper.</p> <p><b>Were the methods reliable?</b> Somewhat reliable. Data about intermediate care teams' perceptions of a good team were only collected via facilitated workshops, which is fairly limiting. Those findings were triangulated with the results of the systematic review, which does not seem entirely justified since the systematic review had a broad focus on interdisciplinary team working</p>	<p><b>groups covered by the guideline?</b> Partly. The views of people included in the SR were not specifically relevant but the population involved in the facilitated workshops are (intermediate care teams).</p> <p><b>Is the study setting the same as at least one of the settings covered by the guideline?</b> Partly. For the facilitated workshops but not the SR.</p> <p><b>Does the study relate to at least one of the activities covered by the guideline?</b> Partly. Not the SR but yes for the facilitated workshops.</p> <p><b>Are the views and experiences reported relevant to the guideline?</b> Partly. The views of intermediate care team members but not necessarily the views reported in the SR.</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>triangulated with the workshop outputs appears to confuse the results and does not seem justified. Although the workshop data are derived from discussions with intermediate care teams, which is positive, it does appear that the results were secondary outputs of the workshops which had been convened to evaluate the impact of an interdisciplinary management tool (IMT). The teams have therefore been chosen for their roles implementing the IMT and we have no idea to what extent they reflect typical intermediate care teams or how their implementation of the IMT influenced their views.</p> <p><b>How well was the data collection carried out?</b> Somewhat appropriately. Appropriate data were collected to address the question of how a good interdisciplinary team can be identified e.g. through the systematic review.</p>	<p>rather than intermediate care in particular. The facilitated workshops did investigate what the research set out to - perceptions of a 'good team' although, as highlighted there were limitations to the data collection.</p> <p><b>Are the data 'rich'?</b> Mixed. The contexts of the data are not well described - we only know that participants are members of IC teams who have implemented the IMT. We are provided with some detail about the factors that are felt to be important characteristics of a good team but the diversity of perspectives are not explored and responses are not compared and contrasted across teams or individuals.</p> <p><b>Is the analysis reliable?</b> Unreliable. There is no description of researchers' involvement in the theming and coding of the output of</p>	<p><b>Does the study have a UK perspective?</b> Yes.</p>	

<b>Internal validity - approach and sample</b>	<b>Internal validity - performance and analysis</b>	<b>External validity</b>	<b>Overall validity rating</b>
<p>However, data collection specifically on intermediate care teams was not reported as being very systematic and appears to have been conducted as part of discussions about the implementation of the IMT. We are told that the workshops were facilitated but we do not know anything about the facilitator except that they are trained. We also do not know what research tools were used to guide discussions. The data analysed by researchers for the purpose of this study was provided from reports from the workshops rather than raw data and we do not know who wrote the workshop reports.</p>	<p>the facilitated workshops, let alone more than 1 researcher being involved in this process.</p> <p><b>Are the findings convincing?</b> Somewhat convincing. The findings are convincing and appear to be internally coherent. However data are not referenced and no extracts from the original workshop outputs are included to support the findings.</p> <p><b>Are the conclusions adequate?</b> Somewhat adequate. The findings are broadly relevant to the aims of the study and there are basic links between data, interpretation and conclusions. The conclusions themselves are plausible but only quite sketchy and lacking in detail. The study does enhance understanding in terms of the characteristics of a good interdisciplinary intermediate care team but it</p>		

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	<p>should be noted that the data collection method for the teams' views is somewhat unreliable and the systematic review data does not relate specifically to IC teams. There is some discussion of study limitations.</p>		