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Supporting Older People's Moves Between Different Care Settings: A Scoping Review

RESEARCH

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ABSTRACT

Context: Moves between care settings in later life present significant challenges for older people. Social care practitioners play a significant role in supporting these moves, but sometimes lack the skills, confidence and resources to meet the needs of older people and their carers.

Objectives: To identify and synthesise unmet move-related needs of older people, the approaches used by social care practitioners, and ways to improve move-related practice.

Methods: We searched 7 electronic databases and grey literature from 25 websites, screening 8535 records published between 2010 and 2021.

Findings: Thematic synthesis of 39 documents focussed on two themes: (1) challenges and unmet needs of older people and their carers, particularly during the planning, decision-making and moving in stages; and (2) insights from good practice schemes and ways to improve move-related social care practice. These include applying a person-centred approach, involving older people and their carers in planning and decision-making, adopting proactive approaches, exploring alternatives to care homes, promoting effective communication and information sharing, and ensuring continuity of care and cross-sector coordination throughout moves.

Limitations: The chosen inclusion criteria resulted in the omission of potentially interesting insights regarding short-term intermediate care and post-move long-term settlement in new settings.

Implications: The review highlights the critical need for comprehensive support and guidance during older people's moves between care settings. It emphasises the importance of practice-oriented information and evidence-based approaches to support older people, their carers, and social care practitioners throughout these transitions.

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INTRODUCTION

Moving between care settings in later life is a complex and challenging process for older people with various 'tipping points', 'triggers' and 'push/pull' factors. Examples include: a crisis event, health situation, changes in family support and/or social relations, housing problems, and the trajectory of decline and receipt of care services (Bäumker et al., 2012; Cole, Samsi and Manthorpe, 2018, 2021; Lord et al., 2016). Although transitions may sometimes be planned, they are more commonly the result of an unexpected crisis or change in older people's health or social relations (Hillcoat-Nallétamby and Ogg, 2014; Means, 2007).

Transitions involve more than just a physical move to a new location (care setting). They also represent a significant life event, with social, psychological and emotional implications (Phillips and Waterson, 2002; Reed, Roskell Payton and Bond, 1998; Tanner, Glasby and McIver, 2015). This may cause several 'feelings of loss' affecting the well-being and identity of older people, including loss of relationships (friends, families and local community connections), independence, belongings, memories, autonomy, decision-making power, choices and dignity (Paddock et al., 2019). Moreover, financial constraints, a lack of choice, fears of losing valued social networks, and concerns over accessibility can all be barriers to moving from their long-term home for older people (Best and Porteus, 2016; Pannell, Aldridge and Kenway, 2012).

Social care practitioners (including social workers, care workers, care coordinators, nurses, occupational therapists and care managers) play a crucial role in supporting older people and their families through transitions. They can provide practical and emotional support, manage anxieties, identify needs, bridge between care settings, source information and ensure they have access to appropriate services (Asquith, Clark and Waterhouse, 2005; Manthorpe et al., 2008; Ray et al., 2015; Sandberg, Lundh and Nolan, 2001). In this spirit, social workers could help prevent, reduce or ease transition experiences faced by older people (Tanner, Glasby and McIver, 2015). To provide better services targeting transitions, social care practitioners have identified the need for a better and more consistent approach to preparing, communicating and supporting older people and their families (Fitzpatrick and Grace, 2019). Investigating the 'optimal time' for a person with dementia to move into a care home, Cole, Samsi and Manthorpe (2018) highlight the importance of access to sufficient information, decision aids and services that are flexible, continuous, well-coordinated and timely. However, in practice, social care staff may lack understanding of the needs of older people and their carers as well as the confidence, guidance or resources in complex and unanticipated cases in practice (Cole, Samsi and Manthorpe, 2018; Fabbre et al., 2011; Manthorpe et al., 2008).

As part of a co-production research project, this scoping review aimed to synthesise the key unmet transition-related needs of older people and to draw together practice-relevant research evidence on transitions into and between social care settings. The goal is to provide practitioners, older people, carers and local decision-makers with coherent evidence to facilitate smoother care transitions, including moves from people's own homes to social care settings (e.g., care homes and extra care housing), between social care settings or from hospital to social care settings. The overarching review questions were: (1) what is known about unmet move-related needs of older people; and (2) how can social care practitioners better support the transition of older people?

METHODS

This scoping review followed the five-stage methodological framework developed by Arksey and O'Malley (2005). First, we developed and refined the review questions based on the discussions with the project team, including social care practitioners, managers and researchers. Second, we developed the search strategy through pilot searches in Scopus, which was adapted for each database (see Table 1).

We searched seven electronic databases and grey literature including guidance, practice-related materials and reports from 25 websites (see Table 2). This was further supplemented by practice-related documents suggested by project team members. All searches focussed on items relating to moves of older people from home to a social care setting or between social care settings or from hospitals to social care settings, and relate to social care support or needs, with limits of

TRANSITION	OLDER PEOPLE	SOCIAL CARE SETTINGS	NEEDS
move OR transition OR movement OR placement	older OR elder* OR senior OR geriatric OR pensioner	'social care' OR hous* OR 'home care' OR 'long-term care' OR 'residential care' OR 'institutional care' OR 'care home' OR 'nursing care' OR 'care for older people' OR 'community care' OR 'extra-care' OR 'extra care' OR 'shelter* care' OR 'shelter with care' OR 'shared lives' OR 'supported accommodation'	need OR support OR experience

Table 1 Key concepts and search terms.

ACADEMIC DATABASES	GREY LITERATURE DATABASES AND WEBSITES
Abstracts in Social Gerontology	Age UK (https://www.ageuk.org.uk/)
Cochrane Library	Alzheimer's Society (https://www.alzheimers.org.uk/)
PubMed	Association of Directors of Adult Social Services (ADASS) (https://www.adass.org.uk/)
SCIE social care online	British Association of Social Workers (BASW) (https://new.basw.co.uk/)
Scopus	Care Choices (https://www.carechoices.co.uk/)
Social Policy and Practice	Carers UK (https://www.carersuk.org/)
Web of Science	Dementia UK (https://www.dementiauk.org/)
	Department of Health and Social Care (https://www.gov.uk/government/organisations/department-of-health-and-social-care)
	Elderly Accommodation Counsel (https://eac.org.uk/)
	Housing LIN (https://www.housinglin.org.uk/)
	Independent Age (https://www.independentage.org/)
	International Longevity Centre (https://ilcuk.org.uk/)
	LaingBuisson (https://www.laingbuisson.com/)
	My Home Life (https://myhomelife.org.uk/)
	National Care Forum (https://www.nationalcareforum.org.uk/)
	National Institute for Health and Care Excellence (NICE) (https://www.nice.org.uk/)
	National Institute for Health and Care Research School for Social Care Research (NIHR SSCR) (https://www.sscr.nihr.ac.uk/)
	Nuffield Trust (https://www.nuffieldtrust.org.uk/)
	Research in Practice for Adults (RiPfA) (https://www.researchinpractice.org.uk/adults/)
	Shared Lives Plus (https://sharedlivesplus.org.uk/)
	Social Care Institute for Excellence (SCIE) (https://www.scie.org.uk/)
	The Health Foundation (https://www.health.org.uk/)
	The King's Fund (https://www.kingsfund.org.uk/)
	Think Local Act Personal (https://www.thinklocalactpersonal.org.uk/)
	Which? Later Life Care (https://www.which.co.uk/)

Table 2 Databases and websites searched.

dates (2010 onwards), language (English) and country (UK only).

Third, the study selection (see Figure 1) was based on the inclusion and exclusion criteria (see Table 3) in two stages: by title and abstract and by full text. W. Zhang and J. Greig acted as the main reviewers for database search results and grey literature items (n = 8535 after removing duplicates) by title and abstract, with the summary list checked by an experienced researcher (R. Darton). The included items (n = 263) were screened in parallel by one reviewer in the project team at the full-text screening stage (W. Zhang, J. Greig, R. Darton and E.-C. Saloniki) and with the summary list checked by A.-M. Towers. When one reviewer was uncertain about the extraction or inclusion of a paper, this was discussed with A.-M. Towers. The full-text review then produced 87 relevant items (including five from secondary searches).

Fourth, a data extraction form was developed and used to chart information from each selected item (n = 87) with the following fields: author (year), country, title, study type, aims, methods, sample size, social care practitioners and care settings. Due to the descriptive nature of some resources, they were excluded from the qualitative synthesis but retained for use in an online resource (https://socialcaretalk.org/older-people-care-moves). Finally, 39 selected items were analysed thematically by the reviewers using a codebook, which was agreed after coding six of the items, and refined and finalised after collating all coding from each reviewer.

Our co-production group members (including three carers, one older person who had moved to extra care housing, four social care practitioners/managers and four researchers) engaged with all stages of the review. The progress and early findings of this review were presented to our co-production group at different stages, which enabled their valuable input in the identification of (sources of) grey literature and refining our findings.

RESULTS

This comprehensive review found limited and fragmentary evidence about social care services around care moves.

Table 4 outlines the key characteristics of the included items (n = 39). Ten focussed on the UK in general, while some were specifically centred on individual countries within the UK: England (n = 15), Wales (n = 3) and Northern Ireland (n = 3). Additionally, eight items had an international scope including UK-based studies. The included items encompassed a range of study designs, including literature reviews (n = 7), qualitative studies (n = 14) and mixed-methods studies (n = 4). In addition to research papers, this review also included 14 items classified as practice-related discussions, guidelines, briefings, etc. These items explored moves between different care settings, including 6 related to hospital to social care settings, 20 on care homes, 8 on housing with care and 5 involving diverse settings.

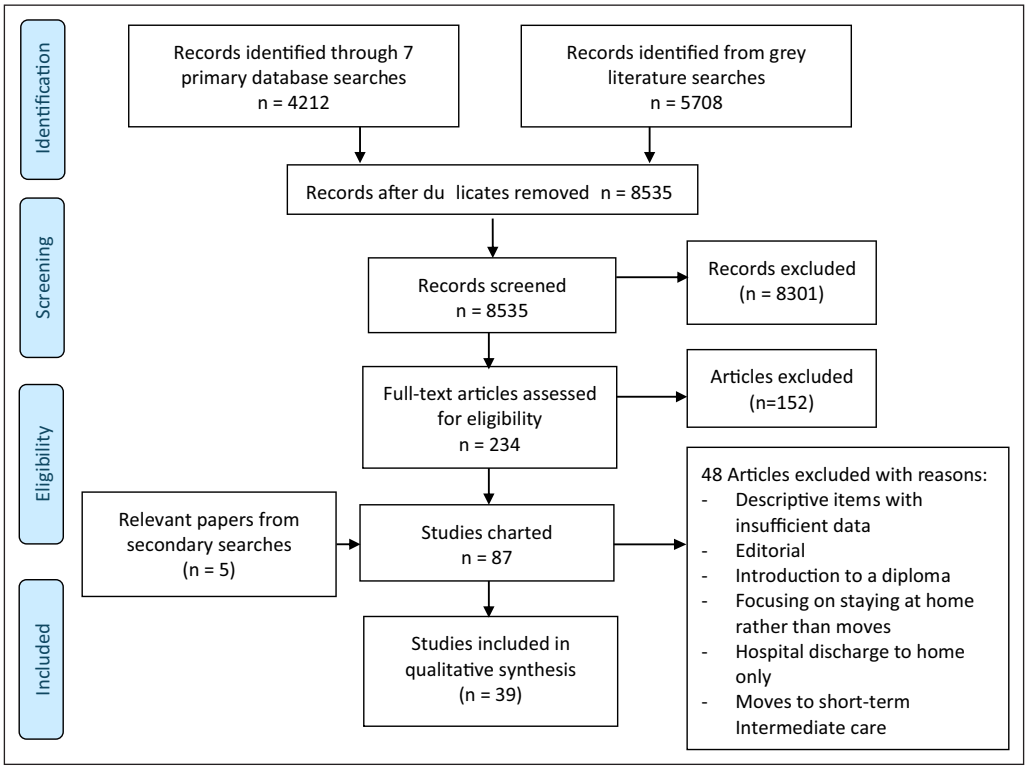

Figure 1 Search and review flow diagram.

INCLUSION CRITERIA	EXCLUSION CRITERIA
-Published 2010 onwards -UK social care systems (including England, Scotland, Wales and Northern Ireland) -Relates to transitions/moves of older people from private home to a social care setting OR between social care settings OR from hospitals to social care settings -Relates to social care support OR social care needs	-Non-UK based literature -Literature in non-English language -Relates only to people who are young adults or children (not including people aged 65 or more) -Relates only to health-related or clinical support/care needs -Destination of moves not to social care settings (e.g., moves to hospitals/private home) -Conference abstracts/proceedings if not published in full -Editorial items -Protocol papers if no findings available -Moves to end of life care -Moves to short-term intermediate care -Duplicate material of the same studies (e.g., summary of research report) -Only about post-move long-term settlement in the new care setting with little information on pre or during transitions

Table 3 Inclusion and exclusion criteria.

Most items focussed on specific stage(s) of care moves, rather than the entire transition process, a pattern also observed in other international review papers included in this study. For example, among the 17 studies identified by Groenvynck *et al.* (2022), the majority focussed on post-transition care home adjustment, with only one US-based study including the entire transition pathway. Despite their focus on different types of care settings or various stages of care moves, all included items acknowledged the complexity and challenges associated with care moves for older people and their families.

The thematic findings are organised into two sections responding to the review questions: (1) unmet needs of older people during the move; and (2) good practice examples and suggestions on how to improve move-related practice.

THEME 1: UNMET NEEDS OF OLDER PEOPLE DURING THE MOVE

Figure 2 summarises the key challenges and unmet needs identified from the review, organised into two stages: the planning and decision-making stage, and the moving-in stage. Detailed discussions of these stages are provided in the following two sections.

Challenges and unmet needs at the planning and decision-making stage

Choosing a care option in later life is a complex and evolving process (Hillcoat-Nalletamby, 2019). This complexity involves various and diverse approaches, including proactive planned decision-making or passive/forced moves when people lack time or capacity to plan/decide in crisis situations (Beach, 2015; Buckland

and Tinker, 2020; Cole, Samsi and Manthorpe, 2018; Competition and Market Authority, 2017; Ellins et al., 2012; Hillcoat-Nalletamby, 2019; Lord et al., 2016; O'Neill et al., 2020; Sury, Burns and Brodaty, 2013; Trigg et al., 2018). Some older people make moving decisions on their own, some with their partner, other family members and sometimes service providers (Beach, 2015; Buckland and Tinker, 2020; Cole, Samsi and Manthorpe, 2018; Hillcoat-Nalletamby, 2019; Lord et al., 2016).

There are key challenges for older people and their carers during the planning and decision-making stage across various dimensions, including emotional, financial and practical aspects. These challenges are linked to the unmet needs of older people, including the need for more funding advice and move planning, better information and advice on appropriate accommodation, and guidance on how to seek relevant information and conduct research in the sector.

STUDY CONTEXT – COUNTRY	
UK in general	10
England	15
Wales	3
Northern Ireland	3
International (including UK-based study)	8
Study design and document type	
Literature review	7
Qualitative	14
Mixed methods	4
Discussion/commentary/guidelines/case study/ report/briefing	14
Move-related care settings	
Hospital to social care settings	6
Care homes	20
Housing with care, etc.	8
Diverse	5

Table 4 Search results for qualitative synthesis (n = 39).

Making decisions to move into a social care setting is widely recognised as an exhausting, daunting, stressful and time-pressured process (Glasby, Allen and Robinson, 2019; Leyland, Scott and Dawson, 2016; Newson, 2011; Northern Ireland Health and Social Care Board, 2013; Redwood, Eley and Gaughan, 2016; Tanner, Glasby and McIver, 2015). Studies highlighted older people's emotional responses to the move, with feelings of anxiety, fear, distress, loss, anger and frustration (Ellins et al., 2012; Fitzpatrick and Tzouvara, 2019; Glasby, Allen and Robinson, 2019; Lee, Simpson and Froggatt, 2013; Leyland, Scott and Dawson, 2016; Newson, 2011; Sury, Burns and Brodaty, 2013), especially when being relocated (Leyland, Scott and Dawson, 2016; Northern Ireland Health and Social Care Board, 2013). These emotional factors need to be recognised and taken into consideration. For example, the Northern Ireland Health and Social Care Board (2013) proposed that meaningful opportunities should be provided to older people to express their feelings about their situation and make sense of what was happening with the move.

The complexities of social care funding systems, along with challenges related to affordability and navigating financial aspects, highlight the unmet needs for advice and facilitation on funding or financial issues associated with care moves (Cole, Samsi and Manthorpe, 2018; Competition and Market Authority, 2017; Lowe, 2016). Financial concerns, such as paying for care, are significant

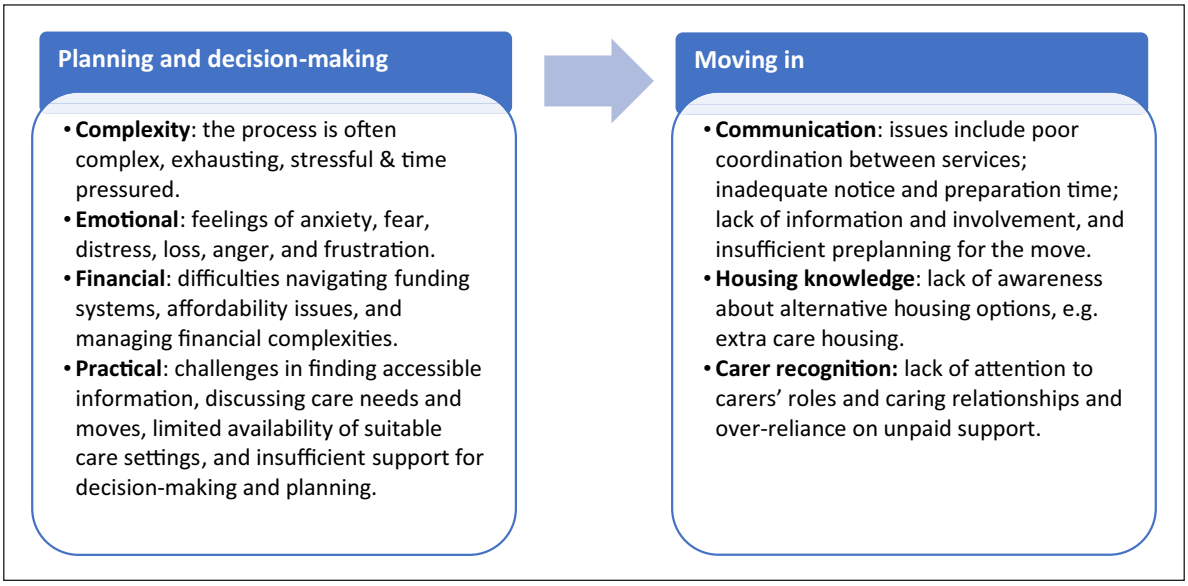

Figure 2 Challenges and unmet needs of older people during the move.

factors in the decision-making process (Cole, Samsi and Manthorpe, 2018; Ellins et al., 2012; Lord et al., 2016). For example, Lord *et al.* (2016) highlighted that almost all carers and people with dementia expressed concerns about the current and future costs of services and care, which significantly influenced decisions regarding the choice of care setting. In addition, older people and their families who fund their own care are disproportionately affected by the financial difficulties of care providers, making their situation more challenging (Lowe, 2016). Meanwhile, others highlighted the greater options that self-funders have around the timing of their moves, compared with those who are publicly funded (Cole, Samsi and Manthorpe, 2021).

Considering practical unmet needs, older people and their carers encounter difficulties in finding accessible information about the availability, quality, cost, terms and responsibilities of services (Competition and Market Authority, 2017; Ellins et al., 2012; Lord et al., 2016; Trigg et al., 2018). Having discussions about care needs and potential moves to care settings can be particularly challenging for some older people (Competition and Market Authority, 2017), while family members may face challenges in making move-related decisions, especially when their relatives struggle with decision-making due to cognitive decline (Scheibl et al., 2019). The limited availability of suitable care settings or properties further compounds the issue for many, reflecting an unmet need stemming from a lack of (understanding and information about) alternative housing choices and support (Cole, Samsi and Manthorpe, 2018; Competition and Market Authority, 2017; Hillcoat-Nallétamby and Sardani, 2019; Trigg et al., 2018).

The responsibility for making choices and decisions in the care market falls heavily on older people and their families, highlighting an unmet need for support and services that facilitate decision-making and planning regarding moves or other care arrangements (Competition and Market Authority, 2017; Hillcoat-Nallétamby and Sardani, 2019; Lord et al., 2016). Social services tend to be reactive and lack a proactive approach in providing advice or information (Ellins et al., 2012). Additionally, people with protected characteristics – such as age, gender reassignment, marital status, pregnancy or maternity leave, disability, race, religion or belief, sex and sexual orientation – covered under the Equality Act 2010, face increased complexities in planning for care moves. This includes those from ethnic minority groups and people living with dementia (Cole, Samsi and Manthorpe, 2018, 2021; Ellins et al., 2012; Richardson et al., 2019; Sury, Burns and Brodaty, 2013; Tanner, Glasby and McIver, 2015; Wood, 2013). For example, transitions for people with dementia should be made when they are still able to navigate 'a new environment, establish new routines, and make relationships with other people' (Twyford, 2018).

Decision-making around care moves is likely to have a longer-term impact on older people's post-move adjustments and their well-being (Manthorpe and Martineau, 2010). A more successful care move and post-move adjustment are associated with a planned proactive decision rather than an unplanned admission (O'Neill et al., 2020). However, in many cases, older people 'have no choice' or no time when it comes to moving time (O'Neill et al., 2020; Sury, Burns and Brodaty, 2013; Trigg et al., 2018). It is widely emphasised that initiating moves early, along with conversations and plans about future care, is crucial for enhancing older people's sense of control over their care and moves, ultimately contributing to better outcomes (Cole, Samsi and Manthorpe, 2021).

Challenges and unmet needs at the moving-in stage

Like the decision-making process for care moves, the transition into a new setting is shaped by individual factors such as uncertainty, identity, and the daily or long-term existence of older people (Ellins et al., 2012; Lee, Simpson and Froggatt, 2013). Above all, older people and their carers frequently encounter communication challenges and unmet needs during the moves. These include: poor communication between services; inadequate notice and preparation time for transfers or discharges; a lack of information and involvement regarding what to expect in the new setting; and little or no preplanning for the actual move itself (Ellins et al., 2012; Fitzpatrick and Tzouvara, 2019; O'Neill et al., 2020; Richardson et al., 2019; Tanner, Glasby and McIver, 2015). Discharge delays and waiting for rooms or a care package pose significant challenges for older people during transitions, as they find themselves in limbo between care settings, uncertain about who is responsible for their care (Ellins et al., 2012).

Research also pointed to a notable lack of awareness about alternative housing options, such as extra care housing, among the general population; remarkably, the majority of residents expressed surprise when they were informed that the scheme was not a residential care home (Buckland and Tinker, 2020) and many older people had varied understandings of what extra care and sheltered housing are (Twyford, 2018; Wood, 2013).

The needs of carers are inherently intertwined with those of older people and their experiences of moves. Specifically, several studies highlighted a lack of attention or recognition of carers' roles and the importance of their caring relationships as well as the over-reliance on unpaid support in transition-related practice (Ellins et al., 2012; Sury, Burns and Brodaty, 2013; Tanner, Glasby and McIver, 2015). Carers often felt they had insufficient engagement in the design of care plans, discharge arrangements and post-admission moves (Ellins et al., 2012; Glasby, Allen and Robinson, 2019; Richardson et

al., 2019; Tanner, Glasby and McIver, 2015). Additionally, there is often inadequate or minimal support from professionals for carers' needs and well-being, especially following the transition (Cole, Samsi and Manthorpe, 2018; Ellins et al., 2012; Jacobson et al., 2015; Tanner, Glasby and McIver, 2015).

THEME 2: MOVE-RELATED SOCIAL CARE PRACTICE

This section presents key themes for improving move-related practice (see Figure 3) and outlines examples of good practice identified from the included papers.

How to improve move-related practice

Several studies highlighted the importance of applying a person-centred approach to facilitate positive moves, which requires services and staff to recognise and value older people as a person with needs, wants and feelings with respect and compassion, rather than as a problem to be solved (Ellins et al., 2012; Newson, 2011; Sury, Burns and Brodaty, 2013). The desired outcome for older people who have moved to a long-term care setting is a healthy transition, that is, a place of living that is caring, welcoming, and where the older person's fundamental physical, safety and love and belongingness needs can be met and valued (Fitzpatrick and Tzouvara, 2019; Jolley et al., 2011; Leyland, Scott and Dawson, 2016).

The person-centred approach requires social care staff to have a good knowledge and understanding of the person, enabling them to support personhood and identity maintenance, including the development of relationships with the person and their family and responding to emotional dimensions of transition-related experience (Newson, 2011; Tanner, Glasby and McIver, 2015). For example, when looking at the use of 'daily living plan' in the transition from hospital to a care home, Thompson and Cook (2012) proposed a collaborative approach, where hospital staff could share psychosocial information with care home staff, and care home staff could collaborate with residents and family members to gather social history and create autobiographical diaries or personal 'scrapbooks'. This reflects the crucial role that interactions with staff have in shaping experiences of using health and social care services. The request was for staff to show more compassion and kindness to patients and families during what can often be anxious and uncertain times (Ellins et al., 2012). A person-centred approach includes consideration of culture, yet Wood (2013) identified the lack of culturally appropriate residential and nursing care available to Black and minority ethnic older people.

The active involvement of both older people and their carers in the planning processes and decisions is crucial and has a significant impact on their transition experience (Cole, Samsi and Manthorpe, 2018; Ellins et al., 2012; Hanratty et al., 2014; Leyland, Scott and Dawson, 2016; NICE, 2015; O'Neill et al., 2020; Thompson and Cook, 2012). Research indicated that older people

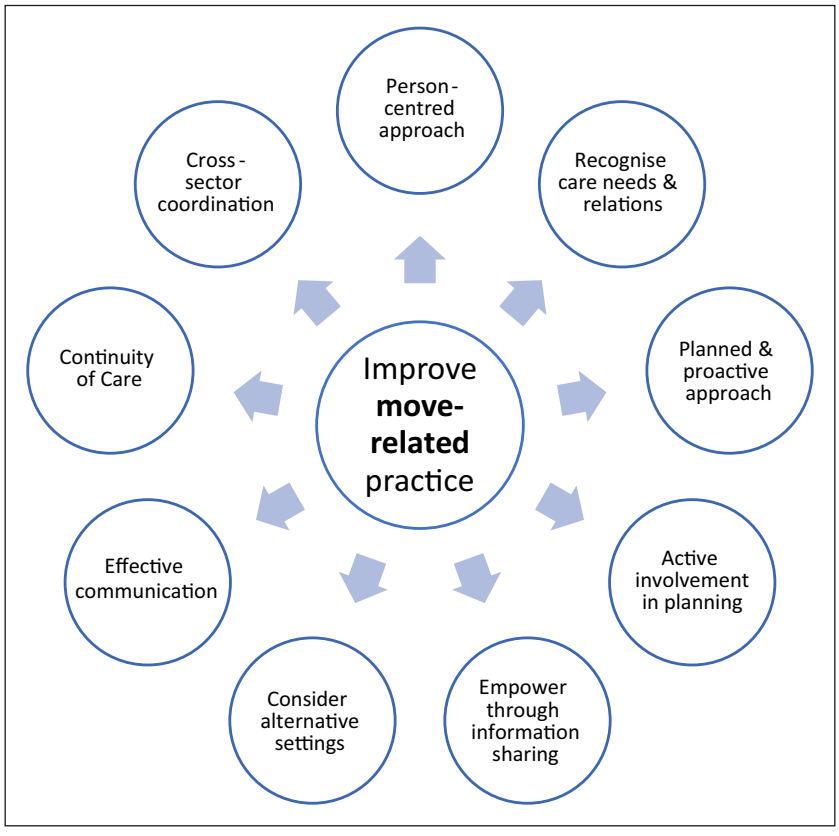

Figure 3 Themes identified on how to improve move-related practice.

valued having a voice in the care process, which helped to foster mutual understanding with various staff and professionals (Ellins et al., 2012). It is important for health and social care staff to pay more attention to the needs of carers in their own right, be more supportive, empathic and accessible to carers, and value the abilities of carers in the process of decision-making and care transitions (Cole, Samsi and Manthorpe, 2018; Ellins et al., 2012). Ellins *et al.* proposed specific suggestions for services to recognise carers as individuals who are affected by the care process and to keep them informed and involved.

Taking a planned and proactive approach reassures older people during transitions by anticipating, planning and managing their care needs, providing guidance, and preparing them for forthcoming changes (Ellins et al., 2012). Some studies highlighted the importance for care providers and social workers to offer more preventative-focussed interventions and information to empower older people to make planned and informed choices about care options and to have realistic expectations regarding life in different care settings (Hillcoat-Nalletamby, 2019; Jolley et al., 2011; Leyland, Scott and Dawson, 2016; Phillips et al., 2015). The perception of choice was suggested as a mechanism to maintain residents' sense of autonomy and enhance overall satisfaction with care (O'Neill et al., 2020). Empowerment for older people arises from material components, such as the provision of information, advice, practical support, financial assistance, physical locations and social interactions (Hillcoat-Nallétamby and Sardani, 2019; Leyland, Scott and Dawson, 2016).

Central to empowerment is the sharing of information about assessment processes, discharge or admission plans, what is happening, what to expect, and providing adequate notice or preparation, all communicated in a sensitive, empathetic and timely manner (Competition and Market Authority, 2017; Ellins et al., 2012; Fitzpatrick and Tzouvara, 2019; Glasby, Allen and Robinson, 2019; Jacobson et al., 2015; Jolley et al., 2011; Leyland, Scott and Dawson, 2016; NICE, 2015; O'Neill et al., 2020; Tanner, Glasby and McIver, 2015; Trigg et al., 2018). This is closely intertwined with proactive support, highlighting the crucial need for services to provide up-to-date, accurate and accessible information, encourage older people to plan ahead, prepare for future moves, and encourage families to talk about risks, care needs and other challenging topics at an early stage (Competition and Market Authority, 2017; Scheibl et al., 2019).

Some papers emphasised considering alternatives like extra care housing and addressing the evolving needs of older people throughout their journey (Hillcoat-Nallétamby and Sardani, 2019; Phillips et al., 2015). Phillips *et al.* highlighted the importance for social workers to understand the diverse types of accommodation and care available to older people, facilitating informed decision-making and realistic expectations. They further suggested that social workers should re-assess and support people with increasing complex needs, such as cognitive impairment and physical frailty, to prevent marginalisation within extra care settings.

Effective communication with older people and their families is pivotal for supporting informed transitions, which can significantly impact on older peoples' well-being (e.g., mitigating anxiety) (Ellins et al., 2012; Glasby, Allen and Robinson, 2019). The good practice guide by the Northern Ireland Health and Social Care Board (2013) suggested that the amount of advice and information provided before relocation affects how older people perceive and adapt to the change: the more information that is given, the smoother the adjustment.

The importance of continuity of care, marked by consistent and ongoing support from social care professionals, like social workers, has been emphasised as a crucial yet often missing or removed aspect in social care practice in England (Ellins et al., 2012; Tanner, Glasby and McIver, 2015). Allocating a key worker to each person during the transition process was proposed to facilitate a smoother transition and ensure personalised care and support (Northern Ireland Health and Social Care Board, 2013; Thompson and Cook, 2012).

Furthermore, the need for better cross-sector coordination in transitions for older people was emphasised across several studies on empowering older people and facilitating successful transitions (Ellins et al., 2012, Hanratty et al., 2014; Hillcoat-Nallétamby and Sardani, 2019; O'Neill et al., 2022; Richardson et al., 2019). Ellins *et al.* highlighted the importance of services and professionals working together in a more integrated manner to ensure smoother transitions between settings, stressing the need for health and social care collaboration at various levels to address the challenges older people face during transitions. Richardson *et al.* particularly emphasised the importance of considering perspectives from both ends of the transition pathway and fostering collaborative approaches, especially in the context of discharges for people living with dementia, to improve transitional care experiences.

Good practice examples

This review found best practice examples supporting move-related social care. Considering different move stages, Hillcoat-Nallétamby and Sardani (2019) evaluated the 'moving on' service in Wales in empowering older people to make a smooth move from their private home to an extra care setting, where caseworkers provided information and advice including financial assistance on relocation costs and practical support. They suggested that a prototype 'moving on' service could be tailored to provide personalised support at one or more phases of the moving process, including pre-move, decision-action, and post-decision phases. For example, during the pre-move phase, the idea of moving could be introduced to older people who begin to face health issues or life

transitions (e.g., retirement and widowhood), leading to connections with health, financial and social care providers, with an initial needs assessment.

Several papers mentioned advocacy services in decision-making and facilitating the transition, mainly focussing on moves to a care home (Competition and Market Authority, 2017; Manthorpe and Martineau, 2010; Northern Ireland Health and Social Care Board, 2013; O'Neill et al., 2020). While acknowledging the benefits of advocacy, for example by giving high visibility and a voice to people, providing recommendations, increasing choice and control, and reducing the chances of inappropriate moves (Competition and Market Authority, 2017; Northern Ireland Health and Social Care Board, 2013; O'Neill et al., 2020), there was no study focussing on advocacy (or its role) in relation to transitioning (Manthorpe and Martineau, 2010). The Competition and Market Authority outlined plans to investigate various advocacy approaches employed across the UK, including statutory advocacy services in Wales and care managers in Northern Ireland.

Some studies referred to specific service or practice elements that effectively facilitate transitions from health to social care settings, including reablement and rehabilitation as transitional care (Ellins et al., 2012). They asserted that these services, by acting as a bridging point, helped to smooth processes of transition and provided structured support throughout the period of change and readjustment. Moreover, their participants especially noted the importance and value of these transitional services in adopting a holistic approach, supporting the 'whole person' and their family, rather than just looking at immediate physical needs.

Examining transitions from rehabilitation to a care home, Thompson and Cook (2012) highlighted the positive views from both hospital and care home staff on the value of a quality 'daily living plan' (DLP) completed by hospital staff, which accompanied the patient to the care home at discharge. However, the DLP frameworks were not well established nor consistently used.

Sometimes voluntary organisations play a significant role in supporting older people and their carers during decision-making and transitions, particularly for self-funders. Age UK, for instance, operates an information and advice line and has Personal Independence Coordinators offering advice and information on various aspects of transition-related issues, including financial aspects of funding care home payments (Lowe, 2016). They also served as advocates for self-funders sometimes, collectively raising awareness about these issues. Another example is the FirstStop Advice Service which provides a national advice line on housing, care options and finance to older people (House of Commons Communities and Local Government Committee, 2018).

DISCUSSION

While many studies have examined the post-move experience for older people entering social care settings, this review specifically concentrated on the planning, decision-making and moving-in stages, revealing limited evidence on social care services during care moves. Challenges encountered during these stages include emotional, financial and practical aspects, underscoring the unmet needs of older people and their carers. These challenges highlight the need for better communication, access to funding and planning advice, better information on appropriate accommodation, and guidance on how to navigate the market. The review also identified good practice examples, such as personalised moving-on services, advocacy services in decision-making, effective communication using 'daily living plan' documents between hospital and care home staff, and information and advice provided by voluntary organisations to self-funders. Thematic recommendations included advocating for a person-centred approach, empowering older people, involving them in decision-making, providing proactive support, and enhancing cross-sector coordination for smoother transitions.

The findings of this review highlight the importance of practice guidance outside the academic world in supporting older people, their carers and social care practitioners before, during, and following transitions (e.g., Jolley et al., 2011; Leyland, Scott and Dawson, 2016), echoing discussions by the Social Care Institute for Excellence (2021) regarding future demands for housing and care. For example, there is little evidence from older people and their carers who have lived experience of moves (Lee, Simpson and Froggatt, 2013) or of professionals' point of view about care moves (Cole, Samsi and Manthorpe, 2018; 2021), and even less that consider the needs of people with protected characteristics (Clark, 2021). Cole, Samsi and Manthorpe (2021) conducted the first study to explore the experiences and views of practitioners on the optimal time for moves to care homes for people living with dementia. Moreover, most of the existing studies around transition were around moving into care homes, with limited attention to other alternatives of care and housing settings for older people (e.g., extra care housing).

The majority of the studies included in the review focussed on publicly funded services, with only a few giving attention to financial considerations. The Competition and Market Authority (2017) highlighted the restricted options available to some local authority-funded residents, underscoring the importance of local authorities allowing and facilitating top-ups to broaden service choices. The Age UK report (Lowe, 2016) discussed self-funders' decisions regarding moving to care homes and financial aspects. Financial matters play a significant role in decision-making, especially

when moving to different types of care settings. Despite local authorities having duties in assessing and supporting older people's care needs, including self-funders as clearly stated in the Care Act 2014, older people and families who fund their own care are more likely to navigate the system on their own. Hence, it is crucial to explore how self-funders perceive the system, identify their key unmet needs and improve practice in supporting them during the move.

This review highlights structural barriers faced by social care practitioners, including cross-sector and inter-agency tensions and communication gaps between services. These challenges can result in transitions to inappropriate settings, unexpected timelines or locations, or the risk of premature transition, creating negative experiences for older people and their carers when their requests get pushed away (Ellins et al., 2012; Higgs and Hafford-Letchfield, 2018; Tanner, Glasby and McIver, 2015). Without adequately resourced social care services and essential infrastructure in place, frontline staff face an almost impossible task in supporting effective move-related social care practice.

Some studies highlighted the importance for social care practice to be evidence-based (Phillips et al., 2015). However, the accessibility of the evidence presents a significant challenge for older people, carers and social care practitioners in searching for and accessing relevant information (Redwood, Eley and Gaughan, 2016). This review found that among the over 8000 items identified, only a handful were relevant, highlighting the necessity for practice-oriented information to aid in navigating the complex system. Additionally, older people, carers and practitioners often face limited or no access to research evidence, and the quality of grey literature from various sources is often uncertain and potentially biased. A key objective of the project was to develop high-quality, accessible materials for these key stakeholders. The relevant resources identified through this review have been organised and compiled into our online resources pack (https://socialcaretalk.org/older-people-care-moves).

LIMITATIONS

This review solely focussed on evidence from the UK or international sources that incorporated UK-based studies/documents, potentially overlooking valuable international evidence and insights. Additionally, our screening criteria excluded short-term intermediate care. Future studies could consider examining both short-term and long-term transitions, particularly relevant to cases involving multiple transitions between care settings, including short-term stays.

CONCLUSION

This review highlights the importance of practice guidance outside the academic world in supporting older people, their carers, and social care practitioners during moves. There is a need for more research to be conducted to fill gaps in the evidence base and consider the needs of people with protected characteristics. Improved accessibility to practice-oriented information is essential, ensuring that it is both easily obtainable and understandable. Finally, the needs of self-funders and their experiences navigating the system should be explored to inform the development of effective practice guidance.

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The authors have no competing interests to declare.

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