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Supporting care transitions for older people: A practice-based qualitative study in England

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Abstract

Care transitions in later life are challenging for older people and their carers. Social care practitioners, including social workers and other professionals, play a significant role in supporting these transitions, such as hospital discharges to care homes and moves between settings, but often face difficulties in providing effective support. This qualitative study explores the challenges experienced by older people, their carers and social care practitioners during transitions, and examines ways to improve transition-related practice. It involved semi-structured interviews with older people who have experienced or are planning to move ($n = 6$), family/friend carers ($n = 11$) and social care practitioners ($n = 10$). Using inductive data-driven thematic analysis, the study identified four themes: (1) unmet practical and emotional needs for older people and their carers, notably in decision-making; (2) barriers to effective practice, including communication, sourcing funding, and system challenges, such as a fragmented health and

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social care system; (3) strategies to improve practice, including person-centred strength-focused approaches, better communication and information access, and understanding diverse care settings; and (4) the importance of supporting practitioners. This study emphasizes the need to equip social care practitioners with necessary tools, training, and systemic support to facilitate proactive decision-making, and improve care transitions and outcomes for older people.

Keywords: co-production; elderly; long-term care; practice; professional; transition.

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Introduction

A long-standing principle underlying UK government policy has been to help people maintain their independence in their own homes for as long as possible. However, the home is not necessarily the only or best environment for ageing well, especially for people receiving high levels of care and support. Among the 10.5 million people aged sixty-five and over in England in 2023, approximately 543,000 were receiving local-authority funded long-term care, amounting to an annual expenditure of £9.3 billion in 2022–23 (NHS Digital 2023). Sixty-two percent of those receiving local-authority funded care were living in the community and 38 percent were in residential or nursing care (NHS Digital 2021). Meanwhile, a growing number of older people are self-funding their care; for example, in 2022–23, 37 percent of care home residents in England were self-funders, with a notable higher proportion of 49 percent in homes for older people (ONS 2023).

Increasingly, housing has been seen as essential in the development of effective social care, and integrated housing with care, or extra care housing, aims to help people maintain their independence (Buckland and Tinker 2020). Those who move to care homes may require support with personal or nursing care that cannot be provided in a domestic setting, or may move due to feelings of loneliness or vulnerability, and extra care housing aims to provide an alternative to some people. Increasingly, care homes provide support for people living with dementia (Wittenberg et al. 2020). Importantly, a substantial proportion of people moving into care homes were previously in hospital (Darton et al. 2012), but difficulties in arranging social care for patients who no longer meet the criteria for hospital care contribute to delayed discharges to home care, a care home or intermediate care (NHS England 2023a).

In this study, care transitions specifically refer to moves into and between social care services, such as care homes or extra care housing. These transitions are significant life events for many older people and their carers, often carrying social, psychological, and emotional

consequences (Tanner, Glasby, and McIver 2015; Paddock et al. 2019; Zhang et al. 2024). The challenges associated with these transitions were exacerbated during the COVID-19 pandemic, when many older people had no other choice but to be discharged from hospital to care homes or ordinary housing with ongoing care needs but insufficient and inconsistent support (Daly 2020; Naylor, Hirschman, and Mccauley 2020).

Social care practitioners—for example, social workers, care coordinators, occupational therapists, care managers, and other professionals in different settings—play a multitude of roles in relation to the transitions of older people (Cole, Samsi, and Manthorpe 2021; Zhang et al. 2024). This can include, for example, highlighting the need for an older person to move, providing advice and guidance, signposting to other services, assessment, identifying suitable placements, or securing funding and review following a move, each of which can present their own challenges (Asquith, Clark, and Waterhouse 2005; Manthorpe et al. 2008; Ray et al. 2015; Milne and Nieman 2025). Social care practitioners work to make transitions for older people successful and positive, providing support to help them move to homes better suited to their needs. However, little attention has been given to the best way to do this, with services relying on the skills of individual staff members to navigate the process with older people and an over-reliance on unpaid support from family or friends (Ellins et al. 2012; Tanner, Glasby, and McIver 2015).

This study aimed to draw out best-practice recommendations for practitioners and co-produce evidence-based resources (available at: https://socialcaretalk.org/older-people-care-moves). This article focuses on the findings from the semi-structured interviews with older people, family or friend carers, and social care practitioners in South East England. The interviews explored transition-related challenges for older people and their carers, identified barriers to good practice, and examined ways to improve transition-related practice and support for social care practitioners in delivering quality care.

Methods

Recruitment and participants

A total of twenty-seven participants were interviewed, including older people who have experience of transitions or are planning to move ($n = 6$), family/friend carers with experience of supporting transitions to different social care settings ($n = 11$) and social care practitioners in different roles and care settings ($n = 10$). Participants were recruited with the support of two local authorities in England, local carer organizations, care providers, and advisory organizations, all of whom distributed

Table 1. Participant characteristics.

Group	Characteristics			Number
Older people (*n* = 6)	Financial arrangements	Self-funded		5
		Publicly funded		1
	Age group	60–69 years		1
		70–79 years		3
		80 years and above		2
	Gender	Male		3
		Female		3
	Health conditions	Dementia		1
		Physical disabilities		1
		Learning disabilities		1
		No significant conditions		3
Family/friend carers (*n* = 11)	Relations	Filial carer		7
		Partner carer		3
		Wider family carer (e.g. grandchild, nephew)		2
		Friend (Power of Attorney) carer		1
	Gender	Male		4
		Female		7
	Conditions of older people	Dementia		7
		Cognitive impairment		1
		Physical disabilities		1
		Mental health issues		1
		Multiple (also counted in respective categories to ensure recognition of each condition)		5
Social care practitioners (*n* = 10)	Roles	Local Authority (LA)	Social worker	3
			Discharge coordinator	1
			Case manager	1
		Non-LA	Discharge coordinator at a rehabilitation hospital	1
			Care home manager	1
			Day centre and dementia café lead	1
			Community navigator	1
			Dementia support officer	1

Note: Several participants in the study had multiple roles, including older people who acted as carers for their families or friends, carers who were themselves older adults (at least four were over seventy years old), carers who had supported more than one family member or friend with different care relationships, and practitioners who shared their personal experiences as carers for older family members who had undergone care transitions. This highlights the universal relevance of care transitions for people in various roles.

information packs or advertisements about the research. Table 1 shows a summary of characteristics of the interviewees.

All twenty-seven interviews were conducted between January and June 2022. Three interviews with older people were conducted face-to-face and twenty-four were via online platforms (Zoom or Microsoft Teams). The interviews lasted between 20 and 62 minutes. One researcher and one of the public advisers conducted four interviews jointly, while the remaining interviews were conducted on a one-to-one basis by

academic or practitioner researchers. Written or verbal consent was obtained from all participants.

Ethical approval for the study was given by NHS Health Research Authority (Reference: 21/WM/0201; IRAS ID: 300025). Local research governance approvals from the two participating local authorities were also received.

Data analysis

Interviews were audio-recorded and transcribed verbatim. Names of people, organizations, and places were replaced with pseudonymized codes. We applied thematic analysis (Braun and Clarke 2006; 2019) to interpret the meanings of the interview data, using a data-driven, inductive approach. Thematic analysis was chosen for its flexibility in identifying, analysing, and interpreting patterns within qualitative data, allowing us to capture a rich and detailed understanding of participants' experiences and viewpoints. One researcher coded all interviews using NVivo 12Pro. A social work practitioner-researcher independently analysed three interviews, using the same process, and compared to the initial coding. Any discrepancies or queries were discussed, until consensus was reached. The co-production (Hartley and Benington 2000; INVOLVE, 2018; Allen et al. 2019) group, comprised of four older people and family/friend carers, four social care practitioners and managers and four academic researchers, reviewed and commented on the initial code structure and early findings based on coding of fifteen out of twenty-seven interviews. Analysis of the interview data was conducted using an iterative process.

Results

Four key themes were identified: (1) transition-related challenges and unmet needs for older people and their carers, particularly in decision-making, feelings of guilt and fear, and lack of practical support; (2) barriers to effective practice and relationship-centred care, such as communication issues, sourcing funding, and system challenges such as fragmented health and social care; (3) strategies for improving transition-related practice, including person-centred, strength-focused approaches, better understanding of diverse care settings, effective communication and information access, and proactive support and engagement; and (4) the need to support social care practitioners by allowing time to build relationships, providing supervision, peer support, organization-level information, and training.

Theme 1. Transition-related challenges

Decision-making

Lack of support and engagement for transition-related decision-making was raised as a key challenge for both older people and their carers. Older people found it especially difficult to access information and advice. Information is increasingly only provided online, and some older people reported this as a major barrier to accessing information. For people with dementia, sifting through different sources of information to make an informed choice is even more challenging.

> *Age UK have provided me with some written papers on advising the sort of accommodation I could move to and contact, but I'm at a total loss, I don't know what to do.*
>
> – OP01, 80, Male, living with dementia

Interviewees emphasized the importance of talking to a person to help them think through how to balance priorities when deciding which (types of) care settings to move into, such as costs, care needs, space, distance to family, whether to make a temporary or permanent move, and at which point to prepare and make the move. Some said it was too challenging to make the significant decision on their own, and with little knowledge, advice or support, they waited for a crisis point to force a decision instead. This was especially true for people with protected characteristics, such as those from ethnic minority groups or Lesbian, Gay, Bisexual, Trans, Queer (LGBTQ) communities, who may have experienced mistreatment in the past and harboured stronger fears or resistance to communal living, as well as potentially having a reduced family support network in later life.

> *If you're an LGBTQ person, so you wouldn't actively choose to go to them […] it takes something quite—like a crisis point, like a severe illness or a fall or, you know, something that kind of takes the decision away almost […] It would be a kind of reactive, there's no other option.*
>
> – CP07, Dementia support project officer

Interviewees also highlighted the 'pains' of multiple moves beyond their control, which were exacerbated during the COVID-19 pandemic. It was common for older people to experience multiple moves between home and care settings in later life, due to, for example, home closures, limitations to public funding, deteriorating health and increasing care needs, and inappropriate discharges/decisions.

> *He was then moved into a ward for elderly men then he tested positive for COVID, so he was put in an isolation ward […] they moved him a long way away from here to a private care home for recuperation […] then*

they moved him again to [town name] so he's now closer to me. But again, he's got to get used to the place and they've got to get used to him.

– FC05, Female, Partner carer

She was in two lots of respite care. A residential unit, a closed ward in hospital and then finally another residential… when she moved to the residential after the respite, they called the doctor for something… he said he could not believe it was the same woman who had been in his surgery six weeks earlier, she really, really nosedived.

– FC03, Female, Filial Carer

She'd kind of established herself there and was terribly distressed to then move to another setting… So she found herself in hospital and that was a kind of familiar setting, then she moved to this respite centre, which became a sort of home for her, and then had to move to more permanent nursing care, so a residential home setting. Again, she didn't want to go there.

– CP07, Dementia Support Project Officer

When it came to facilitating transitions, carers also found it difficult to know what to do and how to best involve the older person in the decision-making process, particularly if they had dementia. Carers valued having other family members with whom they could share the practical and mental responsibility of decision-making, not wanting to be burden on friends and acquaintances.

Guilt and fear

Guilt and fear of the transition and the uncertainty around it was a common theme for older people and their carers. This included fear of moving, loss of individuality, being moved somewhere without giving their consent, post-move loneliness, and fear of mistreatment.

The very thought of what is involved in making the move frightens the life out of me. I'm scared of doing it because I'm just not capable of doing it on my own.

– OP01, 80, Male, living with dementia

Supporting transitions is a stressful and exhausting process for carers. They especially struggle to let go or feel guilty for facilitating moves, particularly if services do not live up to expectations. This can impact on carers' physical and mental health, and upon the relationships between family members.

it's been enormously stressful […] it doesn't take an immediate toll on you like a car crash would. It takes a slow pull from you.

– FC01, Male, Filial carer

> *I feel most strongly about … is how guilty I feel in having facilitated, assisted, encouraged, talked through, somebody going into a home, who afterwards we find the home is not what we hope it is to be.*
>
> – OP03, 91, Female, living with physical disabilities & supported friends' moves

Lack of practical help and support

Going through the complex process of transitions, older people and their carers require practical help, information and advice, for example, about the logistics of moving day and assessments.

> *it's just the physical logistics and not having any help with it.*
>
> – OP06, Male, 64, living with physical & learning disabilities

It is not uncommon that older people live on their own or far away from their families. This is perceived as a challenging situation for both older people and their family carers (if they have any).

> *I think the main difficulty was the distance. And it seemed that care agencies and care workers tended to assume that there would always be some family living locally.*
>
> – FC06, Male, Filial carer

Many carers emphasized their frustration with the insufficient and ineffective communication, noting that health and/or social care staff often fail to listen, show care or adequately inform carers about older people's transition related issues.

Theme 2. Barriers to transition-related practice and relationship-centred care

Interviewees identified challenges faced by social care staff in their daily practice, as well as systemic issues that pose difficulties for all.

A key challenge at a practice level was fostering effective communication and trust with older people and their carers when supporting transitions, which has direct impact on older people and their families.

> *We, as the practitioners, have very little contact with the person and their families at the actual point of preparation and move. It's a case of, oh we've supported you to find a place, over to you and then they go and do it.*
>
> – CP01, Social worker

Practitioners shared many examples of the communication challenges they faced and their impact, particularly in situations where individuals

lack or have fluctuating mental capacity or when disputes arise between older people, their families, and health and/or social care services. These challenges led to difficulty in addressing older people's expectations, emotional responses and reluctance to move, which were further compounded by practitioners' heavy caseloads and time constraints. Despite recognizing the importance of building relationships and establishing trust with those they support, practitioners find it challenging to do so in a limited timeframe.

> *I think a lot of it is managing people's expectations and managing people's anxieties as well […] families have got to—have an identified contact person, they've got to be given all of the information about our processes.*
>
> – CP04, Social care discharge coordinator

Sourcing funding and organizing financial support was another key challenge, morally and practically, for many practitioners. Moreover, practitioners reported difficulty in sorting out care plans and financial arrangements, particularly when family were not in a position to top up publicly funded care or were unwilling to do so.

> *Part of the care needs assessment, and it's always a very difficult question is the first time you're meeting somebody, is you've got to ask about their financial status… lots of practitioners find that very, very difficult… Because if we were to find out that somebody is over the threshold of 23,250, the routes are different.*
>
> – CP04, Social care discharge coordinator

Some social care practitioners went beyond their roles to help older people and their families with practical aspects of the transition; for example, organizing transport or providing practical support with moves.

> *They [older people's family] just loaded my car with all the bits they thought he might want… she was just like, 'Here you go!' and there you go- that was my job! […] it was a whole day of just like doing a move for him.*
>
> – CP05, Community Navigator

There was a consensus among interviewees—whether older people, carers, or social care staff—that most challenges associated with supporting care transitions exist at the system level. This included the division between health and social care, as well as within the social care sector (between different organizations and departments), limited capacity and staff shortages, excessive paperwork and authorization requirements, and limited public budgets and service gaps.

> *We fit into those resources, rather than those resources I guess are adaptable always to our individual requirements.*
>
> – CP07, Dementia Support Project Officer

Sector challenges around workforce capacity and funding are well documented (Devi et al. 2021; Cominetti 2023) but our interviews also highlighted the impact of poor integration between health and social care systems and services, and the impact on practitioners, older people and their carers.

> *Health and social care, is a phrase we use a lot […] It's not where we are.*
>
> – CP05, Community Navigator

Lack of integration led to scattered information and poor cross-team communication. There was repetition of work (e.g. assessing older people's needs) and reports of wasted time and resources (e.g. NHS and social care teams sending multiple care workers to an individual), as well as examples of people falling between the cracks.

> *When somebody goes into hospital, they lose that contact back out in the community […] when somebody goes into a care home, we start our assessments […] if that person is going to go home, then we send the SI [Supporting Independence] team an email saying, Mr X is going home today with a package of care. So in theory, they should be picking them back up again. But people do get lost in the system so we need to have a better system.*
>
> – CP04, Social care discharge coordinator

Sector division and lack of communication are particularly critical when discharging from hospital. Many interviewees felt hospitals discharged people into social care without due care and attention. One care home manager, for example, described a case where a new resident was discharged without necessary medication, placing undue pressure on night staff to provide proper support.

> *The hospital didn't know that we were a new home, so they were going to send her out with no medication […] it is very unfair to expect night staff to welcome in a new person because they haven't got the staff to sit with that person, ease them in, reassure them.*
>
> – CP03, Care home manager

Since the COVID-19 pandemic, the role of social care practitioners who used to be based at hospitals has significantly changed. They have moved out of hospitals and can only conduct needs assessments after patients have been discharged home or to a care home, following the implementation of the 'discharge to assess' model (Department of Health and Social Care and NHS England 2024). According to our interviewees, this can result in multiple and unnecessary moves, which can contribute to their deterioration.

Interviewees said that a lack of communication and cross-team/sector collaboration led to frequent misunderstandings, which in turn, undermined potential partnership working.

> *I do find social services sometimes […] always slightly challenging, and I don't know whether it's just frustration? I think they're probably frustrated with us.*
>
> – CP06, Discharge coordinator at a rehabilitation hospital

Theme 3. How to improve transition-related practice

Considering the wider approach, many interviewees suggested that a person-centred, strength-focused approach, coupled with a more flexible methodology, could lead to better outcomes for older people and their carers.

> *I suppose more flexible approaches in terms of what you can get authorised. It's very sort of black and white and people are put into categories and things in terms of how high their needs are and that can be very, sort of like a blanket approach which is difficult for some people.*
>
> – CP01, Social worker

Interviewees, especially social care practitioners, emphasized the importance of social care and healthcare staff having a comprehensive understanding of the different care settings, including alternative options to care homes, such as extra-care housing, as well as charities that support older people and their carers. Many also highlighted the value these alternative options bring to care and support.

> *Maybe an idea of the different care homes and what they actually deal with. So that then if we're talking to people about moving them from home to a care home, we can actually say 'well, this one would suit because of this' and be able to give them a bit more information.*
>
> – CP02, Age UK dementia café lead
>
> *I think extra care is really important… without that a lot of people could be at risk of ending up in residential care or nursing care that perhaps didn't necessarily need to be there.*
>
> – CP08, Social worker

Recognizing challenges in communication between social care practitioners and older people and their carers, interviewees also highlighted the importance of providing accessible, accurate, and concise information in one place, to enable better-informed navigation of the available support.

> *Lots of people can send you emails with loads of attachments and big brochures of things that you can read about. But when you're in the thick of this environment and you've got so much to do […] I haven't got time to read through a fifteen-page document from the local authority.*
>
> – FC01, Male, Filial carer

Proactive support and engagement in decision-making around transitions was identified as vital for older people and their families. Many interviewees highlighted the importance of the social care practitioner empowering older people and their carers to make timely decisions about care moves, rather than delaying until a crisis or emergency. Practical help and information were also suggested as vital to ensure a smooth transition, for example, advice on what to bring and how to move, and the opportunity to try the new setting for a few days before moving in.

> *If there's something like that [moving to a care home] going on, people need to be told at the beginning because otherwise it's very traumatic when all of a sudden somebody has to move.*
>
> – CP02, Age UK dementia café lead

Interviewees said that support for carers, such as regular updates, should be provided to ensure they remain informed and engaged. Some also suggested providing further support and engagement for carers post-move.

> *I will follow up the next day when someone's gone into care, with their family usually, if they have family […] family need that bit of—I don't know the right word, handholding, comfort, reassurance for someone.*
>
> – CP09, Social worker

Despite many practitioners saying they had no experience of supporting older people with protected characteristics, such as from ethnic minority groups or LGBTQ communities, interviewees recognized the importance of person-centred inclusive practice when supporting people entering or moving between care settings.

> *I'm well aware that there are communities living in the area that I cover with whom I have little contact. Which I would like to think we can reach out to and have, you know, more engagement with for their sake, you know, as we should.*
>
> – CP05, Community navigator

Theme 4. Support for practitioners

A key finding from the interviews with different stakeholders is that organizations need to better support social care practitioners. Social care

is inherently relational, and practitioners need time to support each person. Building trust and understanding the needs of older people and their families takes time. Most practitioners acknowledge that being engaged, caring, respectful, and having strong communication skills are critical in developing effective relationships with older people and their carers. However, the system poses challenges by providing limited time per case, no assigned case workers, and imposing heavy workloads. These obstacles restrict their capacity to build relationships and establish trust with older people.

> *Years and years ago you used to keep your cases for a lot longer so you would have much more of a relationship and a rapport. You have to now develop those skills to be able to build that rapport and relationship very, very quickly.*
>
> – CP09, Social Worker

Another important strategy is to provide supervision and peer support for staff. Examples include: discussing options with the team, identifying ways to provide ongoing support to help practitioners deal with the complex cases, and emotional support and guidance to colleagues.

> *If we've got a complex case that is proving to be stressful for one of our practitioners, we'll have what we call a mini wash up […] like mini supervisions that happen on a daily or every other day basis on each of those cases.*
>
> – CP04, Social care discharge coordinator
>
> *Even though we're meeting lots of people, we're doing that on our own. However, we have a very good line manager. She meets with us every two weeks in person to run through our caseload. That's not just about how we can more efficiently support individuals, but also about our own wellbeing and our own welfare […] Easily said but vital, otherwise one can be very isolated in caring roles and burnout quite quickly.*
>
> – CP05, Community navigator

Instead of individual practitioners having to repeatedly gather local information about logistics, different settings and the contact details of other agencies in the local area, a central up-to-date resource would ensure that practitioners have the latest knowledge and information to provide quality support.

> *We have factsheets about all sorts of things, about going into care, finances, we can look at some of the Age Concern and Age UK information, that isn't specific to us, it's more generalised information. So we can signpost people to perhaps Age Concern or Age UK. But I don't know about what else would help them.*
>
> – CP09, Social worker

Finally, it is important for practitioners to network with other professionals, access training, and the latest knowledge in their field. This was particularly noted as valuable and necessary for non-registered practitioners, such as community navigators, who often have limited access to such opportunities.

Discussion

Older people and their carers need more support throughout the transition process, both practically and emotionally, beginning with decision-making, which is central to maintaining a sense of autonomy in the face of increasing frailty and disability. While other studies have discussed challenges for older people and/or their carers in the transition process (Ellins et al. 2012; Lee, Simpson, and Froggatt 2013; Cole, Samsi, and Manthorpe 2018; O'Neill et al. 2020), this paper specifically focuses on the role of social care practitioners in supporting transitions, recognizes the challenges they face and offers recommendations to better support practitioners.

The COVID-19 pandemic has exacerbated challenges for older people and practitioners across the sector (Curry et al. 2023), including care transitions. In addition, the Discharge to Assess (D2A) approach, introduced in England since 2020 amid the COVID-19 pandemic, grants the NHS greater control and funding over discharges, potentially alleviating pressure on hospitalizations (Redwood et al. 2023; Department of Health and Social Care and NHS England 2024). However, this shift also resulted in social care practitioners (e.g. local authority social workers) being relocated from hospitals, leading to their exclusion from discharge decisions. Consequently, initial discharges may not adequately consider the social care needs of older people, nor the appropriateness and capacity of the discharge settings for their specific requirements, and are often temporary placements. This oversight may lead to multiple and unnecessary moves and can result in a decline in the health and wellbeing of older people and their carers. Recognizing the importance of involving social care teams in the discharge process, there is now a growing trend in some regions in England to bring these teams back into hospital, restoring their role in discharge decisions. This is crucial, as interview findings of this study highlight that multiple moves can pose significant risks to the health and wellbeing of both older people and their carers, while also incurring substantial financial costs in the long run.

From a financial perspective, the Better Care Fund was introduced and extended to enhance integration by pooling budgets and coordinating planning between NHS and local authority commissioners, improving hospital discharge and supporting healthy, independent and dignified lives through joined-up health, social care and housing services

(NHS England 2023b). The government's proposals for health and care integration (Department of Health and Social Care 2022) underscore the significance of joined up commissioning being part of the successful integration in supporting people. In line with this, Integrated Care Systems (ICSs) were legally established across England through the Health and Care Act 2022 to bring together NHS organizations, LAs and other stakeholders in planning services, improving health and reducing inequalities (King's Fund 2022). However, despite these policy developments, there remains a need for further research into how and whether cross-sector joint working is effectively happening on the ground.

Care transitions involve not only hospital discharges but also various other care settings and moves. Our findings highlighted the importance of making and supporting proactive move-related decisions. This involves considering timing, resources, access to information, emotional support, and practical and financial assistance for different care setting options, as well as housing adaptations and funding sources, such as Disabled Facilities Grants (Gov UK 2025). Effective communication among practitioners, teams, and organizations is crucial to ensure a coordinated approach to care transitions. This study also underscores the need to support social care practitioners. The responsibility for better care transitions for older people extends beyond individuals, as many challenges are systematic in nature (Ellins et al. 2012; Tanner, Glasby, and McIver 2015). The organizations/systems should facilitate networking and training sessions for practitioners to improve connections with others in the field, share knowledge, and foster a collective effort.

Social workers, alongside unregistered practitioners, contribute significantly to supporting older people's transitions. While some unregistered practitioners may not identify themselves as social care professionals, their role remains crucial. Initiatives like community care coordinators, jointly funded by local authorities and the NHS, exemplify effective collaboration. Also, voluntary, community and social enterprise (VCSE) organizations, along with volunteers, play a significant role in supporting older people (Cameron et al. 2022; MacInnes et al. 2023). Our findings highlight their importance in facilitating older people's transitions and serving as essential resources for information and advocacy for both older people and their carers. Nonetheless, there is a pressing need for better coordination and resource allocation between health and social care organizations and VCSE organizations to ensure effective joint working and prevent service gaps.

Older people and their carers trying to navigate transitions expect and want health and social care services to be seamless. However, fragmentation at the systems level leads to a lack of coordinated care, with good outcomes relying on the skills, resources, networks and motivation of an already stretched care workforce. Developing practice-oriented guidelines and evidence-based practices, such as the co-produced resources

from the Better Care Moves Study (available at: https://socialcaretalk.org/older-people-care-moves), can improve care transitions for both practitioners and older people and their carers.

Limitations and future research

A strength of this study was its practice-based and practice-oriented approach to co-production, characterized by robust and sustained involvement of social care practitioners, managers, and older people and their carers. However, its scope was limited in scale, with ten social care practitioners, eleven family carers, and five out of six older people being self-funding, resulting in insufficient representation of direct experiences of publicly funded older people. Additionally, the study did not include those decision-makers and practitioners from the health sector. Future research could explore perspectives from both health and social care sectors to explore ways of effective joint working and achieve better care transitions for older people.

Conclusion

This qualitative study emphasizes the need for better practical and emotional support throughout the transition process for older people and their carers. We specifically highlight the role of social care practitioners in supporting transitions, identifying barriers to transition-related practice and relationship-centred care, and proposing recommendations for improvement. Effective communication, proactive decision-making, and adequate support from practitioners are key elements in ensuring smoother transitions. Recognizing the crucial role of social care practitioners in this process, it is imperative to equip them with necessary tools, training, and systemic support to enhance care transitions and improve outcomes for older people. Using a practice-based co-production approach, this study offers tangible insights with clear implications for improving transition-related practice.

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