

Community in-reach and care transition study

Submission date 24/04/2013	Recruitment status No longer recruiting	☒ Prospectively registered ☒ Protocol
Registration date 25/04/2013	Overall study status Completed	☐ Statistical analysis plan ☒ Results
Last Edited 07/03/2016	Condition category Other	☐ Individual participant data

Plain English summary of protocol

Background and study aims

The care of older people in hospital is more complex when compared to care of younger patients. For instance, their hospital stay is often much longer, the risk of complications in hospital is greater, and they are more likely to be admitted back to hospital within 28 days. In hospital, older people are given rehabilitation to help them to get better, exercises to make them stronger and information to help them cope at home once discharged. Currently this is provided by a team of therapists employed by the hospital, and is called the hospital-based rehabilitation service (THB-rehab service). When the patient is discharged from hospital, the hospital team hands this care over to a team in the community, where necessary. This study plans to evaluate a new rehabilitation service. This will be provided by a similar team of therapists, from the community but working in the hospital. When the patient is discharged home, a member of the team will visit the patient at home to ensure the discharge has gone smoothly. This service is called the Community In-Reach Rehabilitation and Care Transition (CIRACT) service. The aim of the study is to measure how effective and how expensive the CIRACT service is as compared to the THB-rehab service.

Who can participate?

Men and women aged 70 and over who have been admitted to hospital on the general medical elderly care ward as an unplanned medical admission. They have been admitted to hospital from their own home or residential care home and have their GP registered within the Nottingham City Primary Care Trust catchment area.

What does the study involve?

Once consent has been obtained and some information about the participant, their health and quality of life has been recorded, the participant will be randomly allocated to receive either the usual hospital-based rehabilitation service (THB-rehab) or the CIRACT service. The THB-rehab therapists will undertake an assessment of the participant's ability to perform certain tasks. Following this assessment, they will provide regular rehabilitation to make the participant better. When they are ready to go home, they will be referred on to the appropriate community-based services for provision of equipment at home, personal care and ongoing rehabilitation where appropriate. Once discharged from hospital, the participant will have no contact with the ward therapy staff. The CIRACT team will undertake an assessment of the participant's ability to perform certain tasks. Following this assessment, the therapist will provide regular rehabilitation to make the participant better and may even include a visit to their home before

discharge. Following discharge from hospital, the CIRACT team will visit the participant at home within 48 hours. During this visit, the level of rehabilitation required at home will be assessed and the CIRACT team will be able to undertake further follow-up visits as deemed necessary. At day 91 all participants are visited at home to ask about how they are getting on. For a small number of participants, we would like to hear in more detail about their experience of the rehabilitation service. Their opinion will be recorded in a private interview. Observations of the participant receiving the rehabilitation will also be conducted with consenting participants.

What are the possible benefits and risks of participating?

Not provided at time of registration

Where is the study run from?

Nottingham Clinical Trials Unit (UK)

When is the study starting and how long is it expected to run for?

June 2013 to November 2014

Who is funding the study?

NIHR Health Services and Delivery Research Programmes (UK)

Who is the main contact?

Eleanor Mitchell

eleanor.mitchell@nottingham.ac.uk

Contact information

Type(s)

Scientific

Contact name

Mrs Eleanor Mitchell

Contact details

Nottingham Clinical Trials Unit
Nottingham Health Science Partners
Queen's Medical Centre
Derby Road
Nottingham
United Kingdom
NG7 2UH
+44 (0)115 884 4926
eleanor.mitchell@nottingham.ac.uk

Additional identifiers

Protocol serial number

13931; 11HC014

Study information

Scientific Title

The CIRACT (Community In-Reach And Care Transition) Clinical and Cost-effectiveness study: the CIRACT trial

Acronym

CIRACT

Study objectives

Older people represent a significant proportion of patients admitted to hospital as an emergency. Their care, compared to younger patients is much more challenging, their stay in hospital much longer, the risk of hospital acquired problems much higher, and the risk of being re-admitted within 28 days, much greater. NHS Nottingham City Clinical Commissioning Group (Nottingham City CCG) currently delivers two rehabilitation services for older people admitted to hospital. The first is the more traditional one, where patients are assessed and managed by the hospital based multidisciplinary team (THB-rehab) and then referred on to community rehabilitation services and social services for personal care. The second is a pilot community in-reach rehabilitation and care transition (CIRACT) service. This is delivered by an occupational therapist, a junior physiotherapist and an assistant practitioner. They provide more intensive hospital rehabilitation, work closely with the patient and their carers, allow a more seamless, integrated discharge back home and then follow up the patient, at home. Compared to THB-rehab, hospital length-of-stay and re-admission rates have reduced over the 4 month period.

We now plan to undertake a more formal clinical and cost-effectiveness evaluation of this service. In parallel we propose to undertake a) a Health Economic study which will inform the cost and cost effectiveness evaluation, using direct enumeration and detailed costing rather than average cost of events, which are often in health economic complex intervention studies and b) a qualitative mechanism and action study, which will inform the explanatory and theoretically evidence of how the CIRACT intervention is implemented and experienced in relation to prevailing modes of service organisation and delivery.

More details can be found at: <http://public.ukcrn.org.uk/Search/StudyDetail.aspx?StudyID=13931>

Ethics approval required

Old ethics approval format

Ethics approval(s)

NRES Committee West Midlands - Staffordshire, 27/02/2013, REC ref: 13/WM/0050

Primary study design

Interventional

Study design

Pragmatic parallel randomised controlled trial including an integral qualitative action and mechanism and health economic study

Study type(s)

Treatment

Health condition(s) or problem(s) studied

Care of the elderly

Interventions

CIRACT service

The CIRACT team will jointly conduct an assessment of the participant's ability to perform certain tasks. Following the assessment a rehabilitation plan will be formulated which will be followed daily. The plan will focus on particular activities which are important to the participant. While in hospital the participants are treated every day (7 days a week) by the CIRACT team and the time of rehabilitation they receive will be dependent on their needs.

During the participant's hospital stay the CIRACT team will liaise with the participant and their carer(s) to visit the participant's home to carry out a home assessment in order to provide recommendations for equipment; make adaptations and/or modifications if required. In more complex cases the CIRACT team will take the participant out of the hospital for a home visit allowing assessment in the participants own home environment, if required.

Following hospital discharge, the CIRACT team will visit the participant at home within 48 hours of discharge. During this visit the level of rehabilitation required at home will be assessed and the CIRACT team will be able to undertake further follow-up visits as deemed necessary. .

THB-rehab service

The THB-rehab service, is provided by the hospital occupational therapy and physiotherapy services on weekdays only. Members of these teams jointly conduct an assessment of the participant's ability to perform certain tasks. Following this assessment the team will provide recommendation for rehabilitation. Depending on this advice, the rehabilitation care starts in the hospital, for instance when physiotherapy exercises need to be learned and these are practices with the participant if time allows. Other rehabilitation care may only require some adaptation in the participant's home and for these the ward team will be asked to refer the participant to the appropriate community based services for provision of equipment at home, personal care and on-going rehabilitation where appropriate at the point of hospital discharge. Once discharged from hospital, the patient has no contact with the ward rehabilitation staff.

Intervention Type

Other

Phase

Not Applicable

Primary outcome(s)

Hospital length of stay from admission to, to discharge from the general medical elderly care ward

Key secondary outcome(s)

1. Super spell bed days (total time in NHS care (all hospital care+ community care / intermediate care) at 28 and 91 days post discharge
2. Unplanned hospital re-admission at 28 and 91 days post discharge
3. Disability (Barthel ADL Index) at 91 days post discharge
4. Health related quality of life (EQ-5D-3L) at 91 days post discharge

Completion date

01/11/2014

Eligibility

Key inclusion criteria

Eligible participants are patients:

1. Men and women aged 70 years and over
2. Admitted to hospital on the general medical elderly care ward as an unplanned medical admission
3. Admitted to hospital from their own home or residential care
4. GP registered within the Nottingham City PCT catchment area
5. Admitted Sunday to Friday

Participant type(s)

Patient

Healthy volunteers allowed

No

Age group

Senior

Sex

All

Key exclusion criteria

1. Previously bed bound
2. Receiving palliative care
3. Moribund on admission
4. Previously included in the trial on an earlier admission
5. Admitted from a nursing home

Date of first enrolment

01/06/2013

Date of final enrolment

01/11/2014

Locations**Countries of recruitment**

United Kingdom

England

Study participating centre

Nottingham Clinical Trials Unit

Nottingham

United Kingdom

NG7 2UH

Sponsor information

Organisation

Nottingham University Hospitals NHS Trust (UK)

ROR

<https://ror.org/05y3qh794>

Funder(s)

Funder type

Government

Funder Name

NIHR Health Services and Delivery Research (UK) Grant Codes: 11/1023/10

Results and Publications

Individual participant data (IPD) sharing plan

IPD sharing plan summary

Not provided at time of registration

Study outputs

Output type	Details	Date created	Date added	Peer reviewed?	Patient-facing?
Results article	results	01/02/2016		Yes	No
Protocol article	protocol	08/02/2015		Yes	No
HRA research summary			28/06/2023	No	No