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Modernising social care services for older people: scoping the United Kingdom evidence base

SALLY JACOBS*, CHENGQIU XIE†, SIOBHAN REILLY†, JANE HUGHES† and DAVID CHALLIS†

ABSTRACT
In common with other developed countries at the end of the 20th century, modernising public services was a priority of the United Kingdom (UK) Labour administration after its election in 1997. The modernisation reforms in health and social care exemplified their approach to public policy. The authors were commissioned to examine the evidence base for the modernisation of social care services for older people, and for this purpose conducted a systematic review of the relevant peer-reviewed UK research literature published from 1990 to 2001. Publications that reported descriptive, analytical, evaluative, quantitative and qualitative studies were identified and critically appraised under six key themes of modernisation: integration, independence, consistency, support for carers, meeting individuals' needs, and the workforce. This paper lists the principal features of each study, provides an overview of the literature, and presents substantive findings relating to three of the modernisation themes (integration, independence and individuals' needs). The account provides a systematic portrayal both of the state of social care for older people *prior* to the modernisation process and of the relative strengths and weaknesses of the evidence base. It suggests that, for evidence-based practice and policy to become a reality in social care for older people, there is a general need for higher quality studies in this area.

KEY WORDS – modernisation, social care, evidence-based policy, systematic review.

Modernisation at the end of the 20th century

The latter half of the 20th century witnessed a reshaping of government and public services across the western world (Organisation for Economic Co-operation and Development (OECD) 2003). By the early 1980s, the

* School of Pharmacy and Pharmaceutical Sciences, University of Manchester, UK.
† Personal Social Services Research Unit, University of Manchester, UK.

post-1945 monopoly of central provision was being called into question, with concerns raised over quality and choice within public services and the increasing financial burden they placed on governments. A number of administrations of the 1980s and 1990s (as in the United Kingdom (UK), New Zealand and Australia) adopted management theories from the private sector and applied them in a raft of public-sector reforms (Hood 1991), but these did not take into account the complexity of public services when applying management processes and 'created a greater need for co-ordination while reducing governmental ability to co-ordinate' (Rhodes 2000).

In the UK, the self-styled modernisation reforms of the incoming Labour administration of 1997 drew heavily upon the neo-liberal reforms of the preceding Conservative administrations whilst attempting to overcome their failings. The modernisation reforms in health and social care exemplified this approach to public policy. For example, *The New NHS: Modern – Dependable* White Paper stated, 'There will be no return to the old centralised command and control systems of the 1970s … but nor will there be a continuation of the divisive internal market system of the 1990s. … Instead there will be a "third way" of running the NHS (National Health Service) – a system based on partnership and driven by performance' (Cm 3807 1997: para 2.1–2.2).[1] In the social care White Paper, *Modernising Social Services*, published the following year, the emphasis was very much on empowering the service user: 'Our third way for social care moves the focus away from who provides the care, and places it firmly on the quality of services experienced by, and outcomes achieved for, individuals and their carers and families' (Cm 4169 1998: para 1.7).

Thus the consumerist approach underpinning the Conservative reforms (Cm 1599 1991), which promoted the direct accountability of public services to the service user and the idea that service quality could ultimately be enhanced through consumer choice, was still clearly evident in the modernisation reforms of the Labour government (Newman 2001). Characteristic of these reforms, however, was their particular emphasis on partnerships and joined-up working (Cowell and Martin 2003). One important aspect of the modernisation of public services in the UK was a pragmatic emphasis on 'what counts is what works'. A belief in evidence-based policy making was evident in key modernisation policy documents, for example, the 1999 White Paper *Modernising Government*, which stated: 'Government should regard policy making as a continuous, learning process, not as a series of one-off initiatives. … We will ensure that all policies and programmes are clearly specified and evaluated, and the lessons of success and failure are communicated and acted upon' (Cm 4310 1999: 17).

Background to the study

In 2002, as part of its stated commitment to evidence-based policy making, the UK Department of Health (DH) commissioned a review of the delivery, commissioning and impact of social care services for four adult user groups (with mental health problems, with physical and/or sensory impairments, with a learning disability, and older people) *before* the influence of modernisation, with the aim of producing a baseline from which to measure the success or otherwise of the reforms (DH 2007*a*). As part of this, four systematic literature reviews were undertaken to find, assess and synthesise empirical studies of adult social-care services. The aim of this paper is to provide an overview of the peer-reviewed research literature pertaining to the *social care of older people* in the UK from the introduction of the community care reforms of the early 1990s to the New Labour reforms at the turn of the 21st century. In particular, it will describe the evidence base that supported the underlying themes of the modernisation process as applied to older people's services in social care. The paper begins with an analysis of UK modernisation policy as applied to social care for older people, providing a framework for the findings. After describing the review methodology, the findings are presented in two ways. Firstly, an overview of the coverage, quality, methods used and overall strengths and weaknesses of the research literature is presented. Secondly, a synthesis of selected substantive findings is presented within the modernisation framework. A full report of the findings may be found in Challis *et al.* (2004*a*).

Modernising social care for older people in the UK

To meet the needs of the research commission, the prevailing themes of the modernisation reforms for adult social care were derived from an analysis of key UK policy and legislation documents. Six themes were thus derived, associated with 20 areas of reform (19 in the case of older people's services: see Table 4).

Integrated health and social care

The compartmentalisation of health and social care services in many countries is rooted in the regulation of health care by either a national health system (as in the UK and Nordic countries) or a social insurance system administered by central government (as in Germany and The Netherlands), whereas social care is overseen by local or regional

government (Leichsenring 2003). Recognition of the need to achieve greater integration of health and social care in these countries is by no means new, but rather has been a recurrent policy theme for 50 years. In 1997, however, the incoming UK Labour government made one of its top priorities to bring down the 'Berlin Wall' that divides health and social services to create a system of integrated care that puts users at the centre of service provision (Cm 4169 1998: 97). Nowhere was this more apparent than in its health and social-care policy proposals, those for older people's services being no exception. Modernisation has entailed a series of initiatives: the single assessment process (DH 2002); *Health Act 1999* flexibilities; NHS Care Trusts (Cm 4818-I 2000); a health and social care model for the management of long-term conditions (DH 2005); and most recently, the joint health and social care White Paper for community services, *Our Health, Our Care, Our Say* (Cm 6737 2006).

Independence

Townsend (1981) argued that the use of long-stay hospital provision for older people and continued investment in the residential care market had contributed towards the structural dependency of older people. Subsequently, many developed-country governments invested in community-based alternatives to institutional care, to promote the independence of older people and to release hospital bed-days (Jacobzone 2000). Independence emerged as an enduring feature of British policies for modernising social care services. For frail older people, initiatives in this regard focused primarily on shifting the location of care away from hospitals and care homes and into people's own homes (Cm 4169 1998; Cm 4818-I 2000; DH 2001; Cm 6737 2006). Policy developments in four constituent areas were apparent: hospital discharge, rehabilitation, the provision of care at home or in home-like environments, and direct payments.

Whilst the closure of long-stay hospital provision for older people predated the recent drive to modernise social care, it is pertinent to this review because of the legacy of community-based services that were its substitute. Subsequently, discharge from acute hospital settings has become a prominent concern of modernisation policies in the UK and elsewhere (Australia, Department of Community Services and Health 1991; Ikegami, Yamauchi and Yamada 2003). In the UK, the Griffiths Report (1988) put forward 'care at home' as a key principle and objective of community care – it has guided the development of services ever since. For example, *Modernising Social Services* stated the following national objective for social services: 'To *enable* adults assessed as needing social

care support to live as safe, full and as normal a life as possible, in their own home wherever feasible' (Cm 4169 1998: 111). Linked to the emphasis on care closer to home, the development of rehabilitation services for older people was promoted. For example, 'active recovery and rehabilitation services' was a core dimension of the development of intermediate care services (broadly defined as services promoting independence, facilitating hospital discharge and/or preventing unnecessary hospital admission), and one of the standards set by the *National Service Framework for Older People* (NSFOP) (DH 2001) that set out the process for modernising older people's services. A final area of enquiry concerned the introduction of direct payments. Cash-for-care schemes that offer cash payments or vouchers in lieu of services have been introduced by the United States and several European countries (Ungerson 2004). In the UK, direct payments were introduced by local authorities with the aim of giving users freedom and independence in running their own lives (DH 2003*a*).

Consistency

Modernisation policies in the UK sought to standardise the response of local authorities in respect of service provision, and three specific initiatives were apparent: the development and implementation of eligibility criteria; extending the range of services available to meet assessed need; and developing effective and transparent costing and charging procedures. The idea of social-care eligibility criteria originated in the White Paper *Caring for People* (Cm 849 1989), and subsequently their purpose was described as to inform users 'about what sorts of people with what kinds of need qualify for what types of service' (Cm 4169 1998: 23). The community care reforms of the early 1990s required local authorities to commission and purchase social care, not to be the primary provider, and thereby to make maximum possible use of voluntary-sector and private-sector provision, but one consequence of this approach has been the fragmentation and uneven development of services. Thus, extending the range of services available to meet assessed need for social care was accorded importance in modernisation policy initiatives such as *Modernising Social Services* (Cm 4169 1998) and the NSFOP (DH 2001). The principle of charging for social-care services predates both the modernisation agenda and the 1993 community care reforms. Variations in charges for various user groups within and between authorities have since been noted (Cm 4169 1998; Audit Commission 2000). Subsequently it was required that the charges are part of the written record of the individual client's care plan (DH 2002).

Support to carers

The care provided to older people through informal mechanisms is an essential backdrop to community care policies in the UK and other industrialised nations (Gibson, Gregory and Pandya 2003). The division of responsibility between state and family appears to stem from both the culture and traditions of a country as well as social policy. For example, in Scandinavian countries and The Netherlands, community service provision is better developed than in central and southern European countries, where family obligations are either assumed or else legislated for (Daatland 2001). During the last three decades of the 20th century, UK policy increasingly recognised the contribution of informal carers to the care of vulnerable adults (Cmnd 4683 1971; Cmnd 6233 1975; Cmnd 8173 1981). Carers were accepted as service users in their own right by the *Carers* (*Recognition and Services*) *Act 1995*, and the first UK national strategy for carers was launched four years later (DH 1999).

Making sure services fit individuals' needs

The norm of fitting care and services to individuals' needs has long been evident in the professional literature (*e.g.* Warren 1946). Based on early experiments in case management in the United States (US) and UK (Huxley 1993), care management became a key change in the UK community care reforms, being identified as a means of providing an effective method of targeting resources and planning services to meet individual's specific needs (Cm 849 1989). It continued to be endorsed in modernisation policies for older people (DH 2001) and in social services more widely (Cm 4169 1998). *Modernising Social Services* also provided guidance to local authorities about how best to commission services. The desired outcome was that commissioning would 'help to ensure that services meet people's specific individual needs, and that groups with particular needs, such as people from ethnic minorities, are better served' (Cm 4169 1998: 36).

The debate about the value of low-level preventative services has been a longstanding concern, evident in *From Home Help to Home Care* (Social Services Inspectorate 1987) and later policy documents. To a considerable extent, however, prevention was given a relatively low priority immediately after the introduction of the community care reforms, for the emphasis was then on targeting resources to those in greatest need (Cm 849 1989). A focus on 'prevention' has returned in recent policy documents (Cm 6737 2006) and been expressed in older people's services in the form of 'Partnerships for Older People Projects' (Cm 6499 2005: para 8.6). At the other end of the care spectrum, the need to target resources – by which frail older people with complex needs receive care of different intensity

and content to that received by service users with less complex needs – currently finds expression in the single assessment process, which specifies four levels of assessment in relation to need (DH 2002).

The workforce

In common with other developed countries (Hussein and Manthorpe 2005), UK policy has recently emphasised the recruitment and retention of staff in the social care of frail older people (DH 2001). In *A Quality Strategy for Social Care*, the importance of the workforce was reiterated: 'Social care staff comprise the greatest asset services possess' (DH 2000: 9). It argued that to develop a competent workforce for the modernising agenda requires (amongst other things) improved recruitment and job retention. Furthermore, in *Modernising Social Services*, an objective for social services was 'to ensure that social care workers are appropriately skilled, trained and qualified, and to promote the uptake of training at all levels' (Cm 4169 1998: 111).

Methodology of the literature review

The review systematically identified, selected, extracted and appraised information from descriptive, evaluative, qualitative and quantitative peer-reviewed research articles that examined social care services for older people in the UK and were published between 1990 and 2004. The key features of the methodology are summarised here, but fuller details may be found in Reilly *et al.* (2008).

Literature searches

Searches of 10 diverse electronic databases were carried out between November 2003 and May 2004.[2] The main search terms included several for social and community care and others for ageing and older people's services (Table 1). To supplement the electronic searches, a number of general journals and those specific to old age[3] were hand-searched for relevant research papers published during 1990 to 2004. The reference lists of the retrieved articles were also scanned.

Inclusion and exclusion criteria

The remit for the review from the commissioners was exceedingly wide – to describe the state of social-care services for older people at the turn of the 21st century. Several criteria were required to accommodate

TABLE 1. *Keywords and search terms employed in electronic searches*

Population or target group	Service area	Type of article/study	Location
Inclusion terms:			
aged	community care	applied research/community care	
ageing	community service*	projects/evaluat*/evidence based	
aging	home care service*	practice/follow up studies/literature	
elder*	social care	reviews/policy evaluation/program*/	
elder* care	social service*	project*/research/research methods/	
elder* people	social work service*	research projects/research reports/	
old age	social work*	review*/service evaluation/social	
old* people		research/stud*/survey*/systematic reviews/trial	
Exclusion terms:			
child*	Clinical	book review	USA
drug abuse	Medicaid	circular	US
drug*	medication	PhD thesis	America*
HIV			Canada
substance abuse			Australia
substance*			

Note: * indicates any suffix or none.

TABLE 2. *Inclusion and exclusion criteria applied in selecting papers for review*

Inclusion criteria: (*all* met for each study)	
Participants/service recipients:	Older people (aged 65+ years) and/or their carers
Service:	Community-based social care[1] or social services
Location:	United Kingdom
Dates:	Data collected between 1990 and 2001 (inclusive)
Design/study type:	Any empirical study.
Focus of study:	Service delivery, organisation, effectiveness or commissioning
Exclusion criteria: (*any* met for excluded studies)	
Participants/service recipients:	'Generic studies' not specifying service recipients
Service:	Any (*e.g.* health, housing or employment) *without* a social care/community component
	Any prison-based/probationary services
	Therapeutic only service
Design/study/publication type:	Non-empirical work; non-peer reviewed papers; grey literature.
Focus of study:	Needs assessment studies with no investigation of services received.

Note: 1. Social care was defined as services provided, commissioned, funded or facilitated by the lead social services agency in a locality.

the breadth and focus of the review and to keep the task manageable (Table 2). The inclusion and exclusion criteria were applied at two stages. At the first stage, the title and abstract (if available) were examined by the lead author of this paper (SJ). If it was expected that the study would meet

TABLE 3. *Assessing methodological quality*

Data extraction sheet items	Responses
1. Is the research question clear?	yes/no
2. Given the research questions and subject matter (and not necessarily other factors, *e.g.* resources, ethics, timescale, experience of researchers), was the design of the study the most appropriate?	yes/no/unclear
3. Is the sample strategy adequate to draw generalisable or transferable conclusions from the study? (consider issues of sample size, number of sites/ locations, power calculations, 'representativeness', attrition and non response)?	yes/no/unclear
4. Is there sufficient detail given on the nature of the intervention/ service/ comparison intervention/ context/setting (including subjects), so that the reader can relate the findings to other settings?	yes/no/unclear
5. Were both the data collection and analysis rigorously conducted (include the study's description of data analysis)?	yes/no/unclear
6. Are enough data presented to permit independent judgement? Are you able to interpret the results?	yes/no/unclear
7. Is the conclusion justified?	yes/no/unclear
Overall score	Range 0–7

Note: 'yes' = 1; no, unclear = 0.

the inclusion criteria, the full text of the article was obtained. At the second stage, the full article was examined and the full criteria applied. Any queries at both stages were addressed collectively by the review team.

Data extraction and assessment of methodological quality

Each paper that met all the inclusion criteria (and none of the exclusion criteria) was abstracted to elicit the following information: study aims, research paradigm, study design, methods of data collection, dates, scope of the study, unit of analysis, key findings and implications for policy and ratings of methodological quality.[4] Most of this information was coded using pre-determined categories that were based on work by Boruch (1997), Gray (1997), and Petticrew and Roberts (2003). In addition, each paper was categorised by its ability substantially to inform or address the six themes of modernisation outlined above.

The scientific quality of papers was assessed in relation to a set of seven *a priori* quality attributes that measured internal, descriptive, construct and external validity (Table 3). Although measures of methodological quality for designs other than randomised-controlled trials (RCTs) are available (Mays and Pope 2000; Spencer *et al.* 2003), none were suitable for a high volume review that included diverse research designs. Aided by these sources and the general evaluation literature, the research team devised hybrid criteria. Positively-rated items (response = 'yes') were assigned one point each and these were summed into a total score. The maximum

possible score was '7', denoting high methodological quality. The internal consistency of this scoring system was examined using Cronbach's alpha, the overall score of 0.56 indicating acceptable internal consistency.[5] Each paper included in the study was read, extracted for information and rated by the lead researcher for this review (SJ). The team of reviewers met regularly to compare and discuss ratings across the four reviews being simultaneously conducted to maximise reliability.

Data management, synthesis and reporting

The unit of analysis was the research paper rather than the study because some studies tackled several research questions and generated multiple publications, sometimes under different authorship. This report opens with an overview of the coverage, study quality and methods used, and a summary account of the strengths and weaknesses of the evidence. Then, reflecting the heterogeneity of the studies, a narrative synthesis rather than a quantitative report is provided (Mays, Roberts and Popay 2001). The scope of the review makes it impossible to describe or even list all the included studies (for which see Challis *et al.* 2004*a*). Instead, literature under three of the six modernisation themes is discussed: *integration*, *independence* and *individuals' needs*. These three were selected for three reasons: (i) their dominance in the UK older people's social-care modernisation policies; (ii) their international relevance – many OECD countries have framed policies to promote deinstitutionalisation and the community care of frail older people (Anderson and Hussey 2000), and that require integrated systems of service delivery (Johri, Belland and Bergman 2003); and (iii) the high volume of identified literature from which the state of services before modernisation can be described. To exemplify, whilst the theme *support to carers* met criteria (i) and (ii), the sparse research evidence prevented a full analysis of these services. Similarly, *consistency* in service provision may have a growing evidence base but the coverage is mainly limited to the UK. Furthermore, the narrative synthesis concentrates on the higher quality studies – those scoring '5' (the median) or above using the seven-point rating described above.

Limitations of the review

Before presenting the findings, it is important to note the limitations of the review. It was not a standard clinical or health-services research review with a narrow focus on the effectiveness or cost-effectiveness of a particular intervention or group of interventions. Difficulties therefore arose with the scope, synthesis and reporting, and these required modifications to the standard methodology of systematic reviews (discussed more fully in

Reilly *et al.* 2008). Firstly, the remit of the review was to describe social care at the end of the 20th century, before recent modernisation policies had had a full impact on services. To capture research evidence from the beginning of the community care reforms to the emergence of the modernisation agenda, a specific time frame was therefore applied – between the *NHS and Community Care Act 1990* and the *Health and Social Care Act 2001*. Studies conducted outside this period were not included, which explains some gaps, *e.g.* more recently published evidence on direct payments for older people's services.

Secondly, we fully recognise that much research evidence on social care has been published in books and reports rather than journal papers. Given the available resources, however, it would have been impossible to review systematically the non-journal literature. Pragmatically selecting peer-reviewed publications did however impose a rough quality-control filter (although clearly there are many exceptions). Thirdly, the review was only concerned with services specifically for older people. In the course of the review, however, some articles were identified that investigated social care in general but that were relevant to older people's services. Such studies were not included as they did not meet the original inclusion criteria and, most importantly, the search strategies were not designed to identify all 'generic' articles. Given the review's design, some relevant publications will have been missed; this influenced our decision not to report work on the *workforce* theme.

One final consideration regards the study quality rating applied to each publication. A scoring system was devised which had to be applicable to both qualitative and quantitative studies, as well as those with mixed methods. There were difficulties, however, primarily as a result of the different traditions and styles of reporting by researchers using the different paradigms and from different disciplines. Qualitative papers as a whole scored less than quantitative papers, with mixed methods papers in between. This did not, however, always reflect less rigour in the research process but sometimes a failure to report in sufficient detail one or more of: the methods of data collection and analysis, information about the sample or sampling; and the findings. It was such deficiencies that prevented a full judgement of quality (not the reviewers' methodological bias, for we have used and published qualitative and quantitative research). It is debatable whether qualitative research should be reported using the same scientific method as, for example RCTs (Mays and Pope 2000). However, papers that do not enable the reader to form their own judgement of the quality of a study also prevent the presented evidence being used to inform further research or, more importantly, to improve services and inform policy.

TABLE 4. *Peer-reviewed publications addressing the themes of modernisation and their associated areas of enquiry*

Modernisation themes and inquiry themes	Number	%	Number[1]	%
Integrated health and social care:			59	25
Developing partnership working	7	3		
Joined-up services	53	23		
Independence:			53	23
Hospital discharge from long-stay settings	8	3		
Hospital discharge from acute-care settings	20	9		
Work opportunities[2]	–	–		
Rehabilitation	7	3		
Care at home or in home-like environments	24	10		
Direct payments	3	1		
Consistency:			37	16
Eligibility criteria and access to services	5	2		
Range of services	18	8		
Charges to users	14	6		
Support to carers:			23	10
Knowledge of entitlement	1	<1		
Assessment and care plan	8	3		
Service provision	18	8		
Making sure services fit individuals' needs:			156	67
Care management (including assessment)	79	34		
Service commissioning	81	35		
Preventative services	5	2		
Targeting assistance	15	6		
Workforce:			25	11
Recruitment and retention	10	4		
Training	17	7		

Notes: 1. Aggregates of sub-totals exceed totals due to multiple categorisation of some review papers. 2. Not operationalised in older people's review.

Findings: an overview of the literature

From just over 7,000 retrieved references, 234 peer-reviewed papers that reported UK studies conducted between 1990 and 2001 of social care in older people's services met the inclusion criteria. Almost one-fifth were identified by hand searches of relevant journals and the reference lists from other publications. Each study was categorised according to the modernisation theme(s) and area of enquiry(s) that it informed (Table 4). Two-thirds of these studies addressed the theme of *making sure services fit individuals' needs*, in particular care management and commissioning, but notably only 10 per cent addressed *support to carers*. The majority (76%) of the publications were descriptive and addressed the scope of a particular problem or needs, the services provided and the process of service delivery. By comparison, far fewer (33%) measured the impact of services for

TABLE 5. *Assessment of methodological quality of studies by modernisation theme*

	Quality scores			
Modernisation theme	0–3 %	4–5 %	6–7 %	Mean
Integrated health and social care	32	24	44	4.6
Independence	28	43	30	4.5
Consistency	11	64	25	4.8
Support to carers	30	48	22	4.4
Making sure services fit individuals' needs	24	37	39	4.8
Workforce	21	54	25	4.4
All publications	23	39	38	4.8

TABLE 6. *Frequencies of attainment of dimensions of methodological quality*

Dimension of quality	Number	Per cent
Clear research question	230	98
Appropriate design	201	86
Generalisable	68	29
Sufficient detail on context/setting/intervention	164	70
Rigorous data collection/analysis demonstrated	129	55
Presentation of results	161	69
Conclusion justified	158	68

Note: Sample size, 234 publications.

older people in terms of effectiveness, cost effectiveness, acceptability or satisfaction. It is striking that only 10 papers reported RCTs, and another four quasi-experimental trials. Furthermore, because there have been so few RCTs, no systematic reviews were found. The studies represent a wide range of research paradigms, from in-depth qualitative investigations of service users' experiences, to economic modelling of service costs. One-half (52 %) of the studies were exclusively quantitative, over one-quarter (27 %) were entirely qualitative, and the remainder (21 %) used a combination of methods.

The methodological quality of the included studies is presented in Tables 5 and 6. It is important to bear in mind the distributions of quality scores for each modernisation theme when considering the review's findings. In particular, it is notable that 23 per cent of the studies were of relatively poor methodological quality (scored between '0' and '3', see Table 5), and less than one-third were assessed as being generalisable or transferable to a wider population (Table 6). Noteworthy also is the fact that almost one-half of the publications failed to demonstrate rigorous data collection or analysis. Whilst for many studies this reflected low scientific rigour, others failed to score positively through poor reporting.

TABLE 7. *Summary of the strengths and weaknesses of the evidence supporting the modernisation of social care for older people*

Themes	Strong evidence	Weak/no evidence
Integration	Primary Care Trusts were slow to engender integrated working practices Integrated service delivery more advanced in old age mental health services than mainstream older people's services	Benefits for quality of service delivery/benefits to users of integrated organisations Benefits of integrated service delivery Generic hands-on care worker
Independence	Organisational issues, often involving co-ordination between health and social services, main cause of delayed discharge Few local authorities offer intensive care management, despite strong evidence for its cost-effectiveness	Social services contribution to intermediate care Impact of day care Use of direct payments with older people
Consistency	Eligibility criteria variable within and between local authorities and becoming tighter Barriers to service use for people from ethnic minorities Inequitable treatment of self-funded admissions to care homes	Extension of range of services to meet assessed need
Support to carers	Separate carers' assessments uncommon and neglect emotional needs High levels of unmet need	Cost-effectiveness of different modes of carer support
Individuals' needs	Barriers to a needs-led/user-focused approach to assessment Predictors of service use/care home admissions	Cost-effectiveness of different forms of care management Cost-effectiveness of preventative/low-level service provision
Workforce	Stress levels are high within social work profession Recruitment and, to a lesser extent retention, a problem in the care sector	Outcomes of training programmes in social care

The findings concerning study methodology and quality from this review, and for the parallel reviews for the other adult user groups, are discussed in greater depth elsewhere (Reilly *et al.* 2008). A summary of the key strengths and weaknesses of the evidence supporting UK modernisation policies for older people's services is presented in Table 7. A strong evidence base may be down to one or two highly generalisable, good quality studies or to a larger number of small studies of lesser quality all of which reached the same or similar conclusions. Instances of a 'weak' or 'null' evidence base arise when only one or two methodologically weak studies were identified or none at all.

Details of the studies

The following section of the paper syntheses the key substantive findings from the reviewed papers that are categorised under the themes of *integration*, *independence* and *individuals' needs*. As explained above, high quality articles that scored '5' or above (on the seven-point scale) were selected for this paper and their key features are presented in Table 8. Where these are cited below, the figures in parentheses refer to the study reference numbers in Table 8. On the few occasions where studies of lesser quality are cited, these are referred to in the conventional manner, as are papers not included in the literature review.

Integrated health and social care

Beginning with evidence of *partnership working*, the identified studies demonstrate that, with particular reference to services for older people, partnerships between social services and the NHS were variable and progressing slowly by the end of the 20th century. Two linked studies (38, 46, 48, 49, 99) described the development of partnerships between health and social services at the NHS primary care group or trust (PCG/T) level. They found that, despite the mandated local authority social services representation on PCG/T boards, general practitioners dominated decision making and social services representatives could be marginalised. Although relationships were improving over time, particularly among frontline staff, the studies concluded that considerable effort was still needed to build relationships and develop trust between agencies. Moreover, continuing organisational flux in the NHS had been likely to disrupt any established relations with social services departments.

Little empirical evidence was identified that demonstrated the often-assumed benefits of agency-level partnership working, either for service delivery or in terms of outcomes for service users. Only one paper (93) sought to address whether integrated structures, such as NHS care trusts, associated with more integrated forms of service delivery. This compared old-age psychiatry services in England with those in Northern Ireland, where health and social services have been jointly administered since 1973. They found that whilst the more integrated structures of Northern Ireland were associated with more integrated systems of service management, aspects of service delivery at the interface with the service user, such as referral and assessment practices, were no more likely to be integrated. Not one paper looked at the associated outcomes for older people.

Turning to the topic of *joined-up services*, the reviewed papers suggest that more progress had been made towards joined-up services in old-age

TABLE 8. *Characteristics of high-quality studies informing review themes of integration, independence and meeting individuals' needs*[1]

	Study	Themes	Design, methods	Subjects, units[1]	Focus of study
1	Abbey *et al.* 1999	IN	S; SCQ	228 C	Survey of visitors to residential homes to investigate quality of care.
2	Addington-Hall *et al.* 1998	IN	S; F2FQ-S	111 SU	Interviews with carers of stroke patients who died at home or in a care home.
3	Andrew *et al.* 2000	IN	Co; F2FQ-S; CA	141 SU	Cohort study of people assessed by social services. Used multivariate analysis to identify predictors of entry to long-term care.
4	Andrews, Kendall 2000	IN	S; SCQ; F2FQ-SS	P: I 105, Q 150	Survey of former nurse proprietors of residential homes following the introduction of the *NHS and Community Care Act 1990*
5	Andrews, Phillips 2000	IN	S; SCQ; F2FQ-SS	P: I 105, Q 150	Survey of proprietors in same study
6	Andrews, Phillips 2002	IN	S; SCQ; F2FQ-SS	P: I 105, Q 150	Longitudinal survey of proprietors in above study
7	Angunawela *et al.* 2000	IND	OR; CR	SU 107	Before and after study comparing the discharge of dementia in-patients from hospital before and after the introduction of the *NHS and Community Care Act 1990*
8	Astin *et al.* 1995	IN	Other[2]	SU	Modelling of GHS and census data to provide indicators of need for home services in one county.
9	Baillon *et al.* 1996	INT	S; SCQ	132 P; 28 T/S	Questionnaire survey of professionals involved in caring for psychogeriatric problems in residential homes.
10	Bamford, Bruce 2000	IN	S; F2FQ-SS; FG	15 SU; 6 C	Explored the feasibility of consulting people with dementia about the types of outcomes they seek from community care services.
11	Banerjee 1993	IN	S; F2FQ-S; CA	169 SU	Compared the prevalence of psychiatric disorders in one community care service with recognition rates of these disorders by community care professionals.
12	Banerjee, Macdonald 1996	IN	S; F2FQ-S	169 SU	Associations between mental disorder and health and social service use in a home care population
13	Banerjee *et al.* 1996	IN INT	RCT; CA	169 SU	Investigated the efficacy of intervention by a psychogeriatric team in the treatment of depression in elderly disable people getting home care
14	Bannister *et al.* 1998	IN	Co; CA	116 SU	Range of patient and carer variables as predictors of residential or nursing home placement.
15	Bath, Morgan 1998	IN	Co; F2FQ-S	1042 SU	Explored associations between physical activity and mortality and service use over time.

16	Bath 1999	IN	Co; F2FQ-S	1042 SU	Explored the use of self-rated health as a predictor for future health and social service use.
17	Bedford *et al.* 1996	INT IN	Co; OR; PE; F2FQ-S; CA	136 SU; 4 T/S	Examined key processes and outcomes in joint health and social services community psychogeriatric teams
18	Bennett *et al.* 2000	IN	S; CR	157 SU	A pilot study to determine the appropriateness of nursing home placements in three inner-London boroughs post 1993 reforms.
19	Boniface, Denham 1997	IN	S; F2FQ-S	1841 SU	Examined the relationships between use of community services and age, health status, social and economic factors, mental wellbeing and gender.
20	Bowling *et al.* 1993	IN	Co; F2FQ-S; CA	640 SU	Explored the socio-demographic, social, psychological and physical characteristics of consistently high and consistently low users of services over time amongst the very elderly (>85 yrs)
21	Bowling *et al.* 1994	IN	Co; CA	640 SU	Assessed health and wellbeing, social and domestic circumstances and need for health and social services amongst very elderly people (>85 yrs)
22	Bowling *et al.* 1995	IN	Co; F2FQ-S; CA	630 and 740 SU	Examined whether increasing service use is associated with level of physical functioning, number and type of health problems, reported need for help, social networks
23	Brown *et al.* 2003	INT IN	QE; F2FQ-SS; CA	393 SU	Evaluated whether an integrated (co-located) primary-care-based health and social care team is more clinically effective than a traditional non-integrated method of service delivery
24	Brown *et al.* 1996	INT IN	Co; OR; PE; CR	120 SU	Examined how community mental health teams for older people work by: identifying which patients pass through process and how contact pattern differs by diagnostic group; and by describing a typical caseload over 18 months.
25	Burch *et al.* 1999	INT IND	RCT; CA	105 SU	RCT comparing the outcome of day-hospital to day-centre rehabilitation.
26	Burch *et al.* 2000	INT IND	RCT; CA	105 SU	RCT comparing day-hospital to day-centre rehabilitation using secondary outcome measures
27	Burch, Borland 2001	INT IND	RCT(add on); F2FQ-SS; CA	153 SU; 101 C; 9 P	Focused on the difficulties and opportunities encountered in the process of attempting to integrate health and social care provision in a day-care setting (alongside RCT)
28	Burholt 1998	IN	Co; F2FQ-S; CR	117 SU	Compared formal service visits and need for help with ADLs and household tasks of older people admitted to residential care with older people who stayed at home
29	Caldock 1993	IN	S; F2FQ-SS	40 P	Explored community care professionals' understandings about assessment arrangements and expectations, opinions and anxieties about anticipated 1993 reforms
30	Challis *et al.* 2000	IN	S; SCQ; F2FQ-S; CR; CA	308 SU	Investigated dependency and general health status of a cohort of older people admitted to care homes.

TABLE 8. (*cont.*)

	Study	Themes	Design, methods	Subjects, units[1]	Focus of study
31	Challis *et al.* 2001*a*	IN	S; SCQ	98 O	Explored whether typologies of care management arrangements for older people could be discerned through the analysis of a series of key indicators.
32	Challis *et al.* 2001*b*	IN IND	S; SCQ	101 O	Examined how intensive care management at home had developed.
33	Challis *et al.* 2002*a*	INT IN	S; SCQ	318 T/S	Described and compared service arrangements in old-age psychiatry across England
34	Challis *et al.* 2002*b*	IN IND	QE; F2FQ-S; CA; other (costs)	86 SU	Quasi-experimental evaluation of a model of intensive case management for people with dementia in a community-based mental health service for older people.
35	Challis *et al.* 2004*b*	INT IN	RCT; SCQ; F2FQ-S	256 SU	RCT evaluating the value of employing a specialist clinician's contribution to the assessment of older people prior to care home entry.
36	Chesterman *et al.* 2001	IN	Co; F2FQ-S	418 SU	Investigated measures of user satisfaction with the care management process
37	Clarkson *et al.* 2003	IND	S; SCQ; FG	16 O	Investigated the potential effect of changing the residential allowance to divert people away from residential care
38	Coleman, Rummery 2003	INT	S; CS; SCQ; F2FQ-SS; TI-S;	72 and 4 O	Examined the role and interpersonal relationships of the social services representative on PCG/T boards.
39	Cox 1997	IN	CS; F2FQ-SS	5 O	Ways in which community care reforms and care management were being implemented in the UK
40	Crawford *et al.* 1999	IN	S; CA	756 SU	Examined whether 1993 reforms resulted in better targeting of residential/ nursing home care.
41	Crawford *et al.* 2001	IN	S; CA	389 SU	Consistency of dependency levels of people admitted to care homes in parts of Northern Ireland
42	Darton *et al.* 2003	IN	S; SCQ; CA; other (costs)	11 900 SU; 618 T/S	Investigated the range of factors effecting costs of care in care homes and the degree to which these factors changed over time.
43	Dening *et al.* 1998	IN	Co; F2FQ-S; CA	2609 SU	Investigated the relationships between health/disability and service contact over time.
44	Edwards, Jones 1998	IND IN	S; F2FQ-S; CA	1405 SU	Examined the ownership of assistive devices; determined their usage and investigated the relationship between ownership and age, gender, living arrangements and disability.
45	Gabbay *et al.* 2003	INT	PE; P; F2FQ-SS; OB; DOC	2 O	Studied how 'communities of practice' work together; how consumers and providers use knowledge in their collective decision-making

46	Glendinning *et al.* 2001	INT	S; SCQ; TI-S	72 O	Explored progress made by PCG/Ts in developing partnerships with local authorities.
47	Glendinning *et al.* 2002*a*	INT	S; TI-S	570 T/S	Investigated patterns of access to medical services for residents in homes for older people
48	Glendinning *et al.* 2002*b*	INT	S; CS; SCQ; F2FQ-SS; TI-S	72 and 4 O	Examined how health and social services are responding to and implementing policies for integrated services
49	Glendinning 2003	INT	S; PE; SCQ; F2FQ-SS; TI-S; DOC		Presented arguments re: macro and meso level constraints and barriers to INT based on two empirical studies
50	Goodman *et al.* 2003	INT	S; FG	44 P	Actual and potential contribution of primary-care nurses in residential homes for older people.
51	Grundy, Glaser 1997	IN	S; other method		Investigated changes in risk of institutionalisation among older people over time
52	Hakim, Bakheit 1998	IND	Co; CR; CA	38 SU	Examined the factors which influence length of hospitalisation of stroke patients
53	Hallewell *et al.* 1994	IN	QE; F2FQ-S; TI-S; CR; CA	121 SU	Explored what happened to frail older people when residential homes close and which factors affected outcome.
54	Hancock *et al.* 2003	IN	S; F2FQ-S	87 SU; 57 C; 95 P	Measured and compared ratings of need for older people with mental health problems by the older person themselves, their carer and keyworker.
55	Hardy *et al.* 1999	IN	S; F2FQ-SS; CR; FG	28 SU; 20 C; 22 P	Explored the extent to which different types of choice had become a reality during care management assessment
56	Hughes *et al.* 2001	INT IN	S; SCQ	101 O	Examined the relationship between care management and the care programme approach in the context of old-age mental health services.
57	Iliffe *et al.* 1992	IN	S; F2FQ-S	239 SU	Examined whether elderly people living alone are an at risk group with a high level of morbidity that makes high demands on health and social services
58	Jacobs, Rummery 2002	INT IND	S; F2FQ-SS; TI-S	570 and 42 P	A study of health service provision to older people in nursing homes to see whether nursing homes have the capacity to fulfil rehabilitation and intermediate care function
59	Jacobs 2003	INT	S; F2FQ-SS; TI-SS	50 P	Investigated the perceptions and experiences of home managers and GPs of the provision of general medical services for older residents
60	Kirchner *et al.* 2000	IN	Other[3]	12 SU	Pilot study examining the costs of care in the community of people with dementia who had behavioural problems
61	Koffman *et al.* 1996	IND	S; CA	1510 SU	Investigated the characteristics and appropriate placement of patients in specialist homes for the elderly mentally ill.

TABLE 8. (*cont.*)

	Study	Themes	Design, methods	Subjects, units[1]	Focus of study
62	Lewis *et al.* 1994	IND	OR; CR	1475 SU	Compared the proportions of patients discharged to private care-homes or elsewhere and lengths of time spent in hospital before and after the 1993 reforms
63	Lindesay *et al.* 1997	IN	S; F2FQ-S; CA	297 SU	Investigated factors affecting the uptake of health and social services by elderly Asian Gujarati
64	Livingston *et al.* 1997	IN	S; F2FQ-S; CA; method11(costs)	700 SU	Investigated the financial costs of formal community services for older people with dementia, other mental health problems and physical disabilities
65	Livingston *et al.* 2002	IN	S; F2FQ-S; CA	1085 SU	Examined service utilisation of older immigrants compared to UK-born counterparts
66	Lloyd 2000	INT IN IND	S; CS; SCQ; F2FQ-SS	202 and 26 SU; 140 and 26 C	Assessments and service provision under the new community care arrangements for people with Parkinson's disease and their carers (as an exemplar of frail older people with complex needs).
67	MacDonald *et al.* 1996	IN IND	S; TI-SS	326 C	Perceptions of carers of elderly long-stay care patients transferred to nursing-homes in three health districts compared with those remaining in long-stay geriatric NHS wards.
68	MacPherson *et al.* 1992	IN	S; SCQ	285 T/S	Survey of the extent and nature of the assessments used by private nursing-homes.
69	Manthorpe, Alaszewski 2002	IN INT	S; SCQ; TI-SS	72 P	Services for people with dementia in a local authority and identified gaps in service
70	Martin *et al.* 1999	IN	S; SCQ	40 O	Examined variations in the needs assessment policies and practices of social services departments in England and Wales in dealing with elderly people who have mental illness.
71	McLeod 2003	INT IND	S; TI-SS		Investigated the degree to which A and E based social workers enhanced health and social care for older people from the older person's perspective.
72	McNamee *et al.* 1998	INT IND	RCT; F2FQ-S; CR; CA; other (costs)	92 SU	Measured the net costs to the health and personal social services of an early supported discharge policy for stroke.
73	McNamee *et al.* 1999	IN	S; F2FQ-S; CR; CA; other (costs)	1055 SU	Quantified service use and costs of supporting frail older people at home in the community.
74	Millard *et al.* 2001	IN	S; other design (modelling); SCQ	6068 SU	Analysed a one-night bed occupancy census to determine whether it was possible to model a total health and social care system for older people.

75	Nelson *et al.* 2002	IN	S; F2FQ-S; CA	1085 SU	Pattern and predictors of service use in representative sample of people aged 65+ living at home.
76	Nelson *et al.* 2004	IN	S; F2FQ-S; CA; other (costs)	1085 SU	Investigated the use, costs and factors associated with service usage amongst people aged 65 and over in inner London.
77	Netten 1992	IN	S; SCQ; F2FQ-S; OB; CA	104 SU	A study of the effect of the social environment of residential care on people with senile dementia
78	Netten *et al.* 2001	IN	Co; F2FQ-S; CA	2438 SU	Use of nursing and residential home care in an older cohort: changes over time including mortality, location, dependency, and relationship between dependency and costs of care.
79	Netten *et al.* 2003	IN	S; SCQ; F2FQ-SS; TI-SS	25 P; 69 T/S; 81 O	Investigated the rate of closure of nursing homes for older people, the types of homes closing and the reasons for closure.
80	Netten, Darton 2003	IN	S; F2FQ-S; CA	921 SU	Investigated the circumstances of self-funded admissions to care homes and compared them to publicly-funded admissions.
81	Newnham *et al.* 1996	IN	S; F2FQ-S; CR; CA	119 SU	Admissions from the community or hospital to private nursing-homes, to assess care management in operation and determine whether admission criteria or access are influenced by funding.
82	O'Dea *et al.* 2000	INT	S; TI-S	49 sites; 49 T/S	Arrangements for provision of general practitioner, nursing advice, chiropody, physiotherapy and speech and language services to nursing homes and the charging policies for those services.
83	Parry-Jones, Soulsby 2001	IN	S; F2FQ-SS	64 then 30 P	Investigated whether practitioners conducted needs-led assessments and any changes in practice post 1993 reforms.
84	Penrice *et al.* 2001	IN	S; CR; CA	304 SU	Investigated why nursing-home care had been recommended for elderly people of low dependency and whether other forms of care may have been more appropriate.
85	Philp *et al.* 1995	IN	S; F2FQ-S; other (costs)	228 SU	Measured and compared perceived financial burden, use of services, and perceived unmet service need of supporters of matched samples of demented and non-demented people.
86	Pollitt *et al.* 1991	IN	S; F2FQ-SS	34 C	Explored the experiences of elderly spouse carers of dementia sufferers and how this influenced their attitudes to and use of outside assistance.
87	Postle 2002	IN	OBal; F2FQ-SS; FG; OB	20 P	Investigated care managers' reactions to the changed nature of their work following the *1990 NHS and Community Care Act.*
88	Proctor *et al.* 1999	INT	RCT; CA	120 SU	RCT of the effectiveness of old-age psychiatry outreach team training on the quality of care in nursing and residential homes
89	Qureshi 1999	IN IND	S; SCQ; F2FQ-SS; FG	89 P; 40 UG	Assessed different perspectives and attitudes towards collecting outcome information in social-care practice.

TABLE 8. (*cont.*)

	Study	Themes	Design, methods	Subjects, units[1]	Focus of study
90	Reed, Stanley 2003	IND IN	P; F2FQ-SS; FG	19 SU; 56 P	Developed and evaluated a daily living plan for older people discharged from hospital to care homes
91	Reed *et al.* 2003	IN	S; SCQ; F2FQ-SS; CR; FG	12 SU; 30 P; 84 T/S	Explored older people's experiences of relocations
92	Reid *et al.* 2001	IND IN	S; F2FQ-SS	19 SU	Explored the question of unmet needs in relation to people with dementia receiving respite services and considered their status as service users.
93	Reilly *et al.* 2003	INT IN	S; SCQ	331 P	Investigated whether integrated structures were associated with more integrated forms of service delivery in old-age psychiatry
94	Richards 2000	IN	OB; F2FQ-SS	25 SU and C; 17 P	Investigated of the ways in which the needs of older people are negotiated during the assessment process. An ethnographic approach.
95	Richardson *et al.* 2000	INT	RCT; other[4]	120 SU	Explored the impact on costs associated with providing an old-age psychiatry outreach team giving training and education for staff in nursing and residential homes. Part of an RCT.
96	Robinson, Drinkwater 2000	INT IN	PE; FG; other[5]	11 SU; 1 T/S	Explored the process of care provided by a mutidisciplinary (inc. social work) community-based geriatric assessment and management team using a critical incident approach.
97	Ross, Tissier 1997	INT IN	PE; CS; F2FQ-SS; CR	351 SU; 1 T/S	Evaluation of the GP practice as a setting for assessment and care management; the potential benefits of co-ordinating social work and district nurse assessments of needs of older people.
98	Rothera *et al.* 2003	IN	Co; CR; CA	1888 SU	Investigated dependency and health status of a cohort of older people admitted for long-term nursing or residential care and compared these findings with assessments conducted by social services departments prior to placement.
99	Rummery, Coleman 2003	INT	S; CS; SCQ; F2FQ-SS; TI-S	72 and 4 O	Examined the development of partnership working between PCG/Ts and social services departments for the delivery of services, particularly whether integration into one organisation was a desirable or feasible goal.
100	Schneider *et al.* 2002	IN	S; F2FQ-S	132 SU	Investigated what services people with dementia and their carers used; what factors were associated with service receipt; what services informal carers provided; and what was the effect of different living arrangements.
101	Schneider *et al.* 2003	IN	Co; F2FQ-S; CA;	132 SU	Explored the variations in informal and formal care costs according to the living arrangements of people with dementia, by level of dependency and over time.
102	Shepherd 1996	IND	S; F2FQ-SS; TI-SS	100 SU; 36 C	Examined user and carer experiences of and views about arrangements for hospital discharge and the community support provided afterwards.

103	Stern *et al.* 1993	IN	S; SCQ	4678 then 6079 SU	Determined the changes between 1979 and 1990 in demography and dependency levels in a repeated census of older people in residential care.
104	Stewart *et al.* 1999	IN	S; DOC	50 AF	Analysed a nationally-representative sample of social services assessment documents for older people for content and coverage.
105	Stoddart *et al.* 2002	IN	S; SCQ	1540 SU	Examined the socio-demographic and health determinants of the use of both statutory and private home-care services by older people living in the community.
106	Tanner 2001	IN	CS; F2FQ-SS	12 SU	Investigated the subjective meanings for older people of: needs experienced at the time of referral to social services; significance of decision of social services not to meet needs; implications of this decision on day-to-day lives; self perceived outcomes.
107	Temple 2002	IN	S; FG	3 T/S	Examined and prioritised social-care needs for older people from three ethnic minority groups.
108	Trieman *et al.* 1996	IND	QE; CA	71 SU	Examined the outcomes of older functionally mentally-ill patients who had left long-stay hospitals in comparison with a similar group who stayed there.
109	Victor *et al.* 2000	IND	S; CR	456 SU	Examined the extent of the delayed discharge of older patients from acute hospital wards and analysed the factors associated with such delays.
110	von Abendorff *et al.* 1994	IN INT	S; diary	16 P	Examined the distribution of time use by different professional staff working in two community mental health teams for older people
111	Walker *et al.* 1998	IND IN	S; F2FQ-S; CA	756 SU	Compared rates of mental health problems, disability and use of health and social services of older people in sheltered accommodation with age peers in rest of the community.
112	Ware *et al.* 2001	IN	S; SCQ; F2FQ-SS; TI-SS	161 then 211 T/S; 11 O	Investigated the development and changes in the local-authority funded market for home care between 1995 and 1999.
113	Ware *et al.* 2003	IN	S; F2FQ-SS; CR; time1	55 SU; 37 C; 28 P	Examined how community care was being arranged, delivered and received. Views of older people, carers and care managers. Follow up to Hardy *et al.*, 1999.
114	Warnes *et al.* 1997	IN	S; other method	67 PC (mean pop'tn 1774)	Investigated the characteristics of elderly populations associated with variations in their use of community health and personal social services.
115	Weinberg *et al.* 2003	IN	S; diary	34 P	Assessed the pattern of working practices of care managers working with older people.
116	Weiner *et al.* 2002	IN	S; SCQ	101 O	Different care management arrangements for older people's services post-1993 reforms.
117	Weiner *et al.* 2003	INT IN	SCQ; TI-SS	101 then 18 O	Investigated the range and scope of the care management role undertaken by health-care professionals in the care of older people

TABLE 8. (*cont.*)

	Study	Themes	Design, methods	Subjects, units[1]	Focus of study
118	Wenger 1999	IN	S; Co; F2FQ-S	490 then 72 SU	Explored the impact of the implementation of the *1990 NHS and Community Care Act* in 1993 on service use and provision and considered views and preferences of older people to paying for care and sources of care.
119	Wills, Leff 1996	IND	S; F2FQ-S; OB	110 SU I; 174 O	Compared the quality of life for psychogeriatric patients in a long-stay psychiatric hospital with that in four community residences developed as part of a reprovision programme for the hospital.
120	Wills *et al.* 1998	IND	S; F2FQ-S	168 P	Investigated whether community-based facilities were successful in establishing a home-like environment for ex-hospital psychogeriatric patients and the impact on quality of life.
121	Wittenberg *et al.* 2001	IN	Other[6]		Made projections of likely demand for long-term care for older people under different scenarios.
122	Wood, Castleden 1993	IND IN	S; F2FQ-S; CA	497 SU; 20 T/S	Compared features of public and private sectors providing care for older people.
123	Wright 1994	IND IN	S; CS; SCQ; F2FQ-SS; OB	105 then 6 T/S	Investigated the type and scope of services provided by multipurpose homes and described the benefits and drawbacks of this model.
124	Wright 2003	IN	S; CS; SCQ; F2FQ-SS; TI-SS	56 SU	To identify and explore the significant and controversial issues affecting the key actors involved in older people paying the full cost of their long-term residential or nursing-home care.

Key to themes: IN individuals' needs; IND independence; INT integration.
Key to design and methods: Co cohort; CA client assessed; CS case study; DOC document review; F2FQ-S structured face-to-face interviews; F2FQ-SS semi-structured face-to-face interviews; FG focus group; OB observation; OR outcome evaluation; P participatory; PE process evaluation; QE quasi-experimental; SCQ self-completion questionnaire; TI-S telephone interviews (structured); TI-SS telephone interviews (semi-structured).
Key to subjects or units of analysis: AF assessment forms; C carers; I interviews; O observations; P professionals; PC postcode sectors; Q questionnaires; RCT randomised-controlled trial; SU service users; T/S team/service; UG user groups.
Other notes: 1. Papers scoring '5' or above out of a possible '7' on different aspects of quality. 2. Other design (modelling); other method (secondary analysis). 3. Other design (cost analysis); diary; other method (costs). 4. Other design (economic evaluation); other method (costs). 5. Other method (critical incident technique). 6. Other design (modelling); other method.

mental health services than in mainstream older people's services, possibly following the lead of old-age psychiatry. The evidence for integrated working in old-age mental health services was strongest for liaison and training (33). In particular, there were many close links with care homes, which had better access to and relationships with psychogeriatric services than with other specialist health services (9, 58). There was less evidence, however, of formal integration through, for example, shared management of staff. In 2000, only 59 per cent of old-age psychiatry teams had social-care staff as members (33).

Some papers documented the benefits of social worker placement in general practitioners' (GP) surgeries, both for users and their carers (ease of access) (23) and for the staff involved (closer inter-professional working) (97). Integrated systems of care management, however, by which health-care staff assume responsibility for co-ordinating care packages, as suggested in the early guidance (Social Services Inspectorate and Social Work Services Group (SSI/SWSG) 1991*a*, 1991*b*), were slower to develop and difficult to maintain. A national survey of local authorities in 1997/8 demonstrated that only 21 out of 101 respondents had NHS staff acting as care managers for older people (31). A follow-up study in 2001 found that this was still the case in only 14 of these authorities (117). Moreover, the effectiveness of this and other existing models of integrated care-delivery in the UK remains to be evaluated.

This review revealed little evidence of the development of a generic health and social-care worker for older people. Whilst earlier studies had demonstrated the role's potential (*e.g.* Challis *et al.* 1991*a*, 1991*b*), only one paper meeting the inclusion criteria for the current review (but not the median quality score) explicitly evaluated the development – it was a small process evaluation that demonstrated equivocal success (Taylor 2001). Indeed, despite the widely held presumption that integrated services are favourable for older people, evidence of their benefits was generally lacking, as other reviews have found (Dowling, Powell and Glendinning 2004). There is, however, clear evidence of the barriers to integrated health and social care among the reviewed paper (23, 97) and elsewhere (Johnson *et al.* 2003). They include professional mistrust, threats to professional identities, and problems with information sharing.

Independence

Studies of *hospital discharges* of older people from long-stay hospital wards were not well represented during the review period – in contrast to the 1980s, when discharge from acute hospital care, in particular delayed hospital discharge, was a prominent theme. The reported incidence of

delayed discharge in studies identified for the current review averaged around 25 per cent of admissions (61, 109). The identified reasons for delayed discharge were delays in: care-home placement (7, 52, 61, 109), the assessment process (7, 109), and the completion of care packages including necessary home adaptations and equipment (52), and the absence or breakdown of carer arrangements (7, 109). Other factors such as access to rehabilitation in hospital, dependency and age were not found to be significant causes. In other words, organisational issues, including many involving co-ordination with social services, were identified as the main cause of delayed discharges.

Moving on to *rehabilitation*, few peer-reviewed publications were found on the contribution of social services to rehabilitation in older people's services, and those identified did not rate highly on the seven quality criteria. For example, one study which sought to identify the different models of community rehabilitation in the UK and that collected data on the structure of 98 different teams failed to examine explicitly the involvement of social-care staff (Enderby 2002). Another study of community rehabilitation that did investigate aspects of integration with social care compared only six teams (Geddes and Chamberlain 2001). Variations in team structure and the services offered were assumed to relate directly to the particular purpose of each team, and a taxonomy of four types of rehabilitation service was proposed. It is hard to draw any conclusions relating to social care from such a small sample, however, and no identified studies investigated the relative benefit of integrated teams for older service users. One of the few identified RCTs was high quality and compared day-hospital rehabilitation to rehabilitation by health staff in a social-services day centre (25, 26, 27). Whilst the outcomes were similar for older people and their carers in each setting, the day-centre model was less popular.

The focus on rehabilitation in older people's services has been largely subsumed by the intermediate care agenda in the UK (Cm 4818-I 2000), but peer-reviewed evaluations of intermediate care services that explicitly involved social services were scarce: only three papers were identified in the current review and only two scored '5' or above on quality. One of these was an RCT of an integrated supported early-discharge team for stroke patients (72). Despite the small sample size, this study suggested that the intervention was a cost-effective alternative to hospital care in the management of stroke. The remaining paper which could inform developments in intermediate care was descriptive and examined access to health care for older residents of care homes taking a mixed-methods approach. It found that whilst access to therapy services was possible for most homes, it was often difficult and had to be paid for privately, with

potentially some negative consequences for the sector's capacity to provide intermediate care services (58).

Care at home or in homelike environments

In relation to this area of enquiry, two services covered by the research literature will be considered here: day-care services and intensive care management for older people. Day-care services offer both social and respite care and facilitate interactions between older people. Several benefits of day care were suggested in the reviewed papers but they had below the median quality scores: social interaction, improvements in mood and behaviour of dementia sufferers, improved social functioning and avoidance of admission to residential care (Curran 1996; Powell 2000). No rigorous evaluations of the impact of day care were identified, but included papers did suggest that day services were changing. For example, new developments, such as integrated day-centre rehabilitation and day-care provision in multi-purpose care homes were evaluated but demonstrated variable success (25, 26, 27). An intensive-care management demonstration study (34) met the inclusion criteria and indicated the capacity of this approach not only to provide an alternative to care-home admission but also to improve wellbeing and support to carers. By 1997/8, however, only five per cent of English local authorities provided such a service (32), despite no evidence of the cost effectiveness of less targeted forms of care management (discussed further below).

Direct payments

Given the reference period of the current review (1990–2001), it is unsurprising that little empirical evidence was identified concerning the use of direct payments by older people. Just one small study in a peer-reviewed journal was identified (Leece 2001), for which only three older users of direct payments were interviewed.

Making sure services fit individuals' needs

Assessment and care management

The general anxiety felt by community-care professionals prior to the introduction of the 'new' process of assessment for care management was highlighted in a 1993 paper, the year of full implementation of the community care reforms (29). This qualitative study identified three issues of concern that later became recurrent themes in the literature: the conflicting role of the assessor; the identification of unmet needs; and,

in particular, difficulties in conducting a needs-led assessment. Most papers in this review that examined the assessment process were concerned with the success or failure of a needs-led approach to assessment. In this respect, studies provided evidence of the way in which social workers' concepts of needs were inextricably linked to services and eligibility criteria (83); that with ever-tightening budgets, assessments were becoming even more resource-led (83); that user choice in the assessment process was restricted (55, 113); and that despite older people's reluctance to enter care homes, they often acquiesced to professional recommendations (91). There was also debate about the desirability of structured assessments. A nationally-representative survey of 50 assessment documents, whilst highlighting wide variations in the domains covered by these instruments, found that most were structured, some highly so (104). Whilst promoting consistency in the assessment process and aiding the generation of aggregate data, structured assessment forms were also criticised for their inflexibility (Ellis, Davis and Rummery 1999), and incompatibility with users' perceptions of need (Rummery, Ellis and Davis 1999). These papers did not provide a full account of their methodology and did not reach the median quality score.

Despite the provision of guidance on care management (SSI/SWSG 1991*a*, 1991*b*), this review found marked variation in the ways in which care management developed following the *NHS and Community Care Act 1990* (32, 116, 117). In particular, as reported earlier, very few local authorities employed NHS staff as care managers, indicative of more integrated forms of care co-ordination, and even fewer operated intensive-care management schemes for older people. Budgetary devolution to care managers was rare (39), and systems for the monitoring and review of care packages poorly developed (55, 113). Many of these aspects of care management were vital to the success of the original demonstration studies (Challis 1993) that targeted the most highly dependent older people at high risk of care-home admission. Instead, the identified papers suggested that care management had become a process applied to all older people referred to social services departments, irrespective of need. Moreover, there was no evidence of the relative cost-effectiveness of different models of care management for older people.

Service commissioning

Included papers provided useful information for service commissioning in terms of measuring service use, unmet needs and costs; issues affecting social-care markets; methods for measuring outcomes; and user involvement in commissioning processes, but few looked at the commissioning

process itself in detail. Several studies aimed to identify the predictors of domiciliary and day-care use and care-home admissions. The most commonly identified predictors of home care, and those most strongly associated with service use, were dementia (64, 73, 76, 100), living alone (or the absence of a cohabitant or family carer) (19, 51, 64, 73, 76, 100, 114), physical dependency (or activity limitation) (12, 19, 21, 22, 64, 73, 76) and age (19, 43, 44, 51, 64). Living alone (19, 57, 65, 75) and dementia (19, 65, 75, 85) were also the most commonly reported predictors of using day-care services. Of particular interest to policy-makers and planners aiming to divert older people away from institutional care were studies that identified factors associated with care-home admission. Again, dementia (and its severity) was identified as one of the strongest predictors of admission (3, 14, 17, 78), but also influential was whether there was a family carer, her or his ability to cope and their level or stress (3, 14, 17, 51, 78). This is a clear indication of the potential of carer-support services to help maintain older people for longer in their own homes. Interestingly, a national study of care-home admissions (78) concluded that characteristics of the individual explained over 80 per cent of admissions, and that supply factors, although significant, added nothing to the power of the statistical model developed. One surmises, therefore, that up to 20 per cent of admissions may be explained by service-related factors, which are open to modification by service planners.

Preventative services

Only two papers that explicitly investigated the provision of low-level preventative services met the inclusion criteria. Both qualitative studies, they provided evidence of the value placed on such services by older people. One suggested that help with housework was instrumental in allowing older women in particular to remain in their own homes (Clark and Dyer 1998), but provided insufficient detail of the methodology to allow a full judgement of quality. The other described difficulties faced by older people in asking for help from others when statutory services were unavailable (106).

Targeting assistance

Most publications on targeting concerned the appropriateness of care-home placements. It has been estimated that almost one-third of those admitted are inappropriately placed or have a low level of dependency (18, 30, 81, 84, 124). Variation in placement decisions between different areas was demonstrated for both England (78) and Northern Ireland (41).

These authors suggest this is likely to be due to the availability and success of alternative services aimed at maintaining people at home for longer.

Discussion

This review has uniquely taken a systematic approach to the identification, critical appraisal and synthesised evaluation of the peer-reviewed research literature pertaining to social care for older people. By doing so, it has provided not only a picture of the state of these services in the United Kingdom at the end of the 20th century but also identified where further investment in research is required to improve the evidence base. The review has demonstrated where the research evidence is strong (Table 7) and may have helped inform policy change. For example, in relation to delayed hospital discharge, the evidence strongly suggests that the main causes relate to organisational issues, particularly at the interface of hospital and community. The *Community Care* (*Delayed Discharges etc.*) *Act 2003* subsequently placed new duties and responsibilities on both social services authorities and the NHS, thereby recognising the joint responsibility for ensuring timely discharges (DH 2003*b*). Whilst this may represent 'evidence-based policy' in action, it could also be argued that other drivers for change were as important, such as financial and political pressures to eliminate problems of 'bed-blocking'.

The review has also identified weaknesses in the evidence base, both in terms of gaps (Table 7) and in respect of the quality of published studies (Tables 4 and 5); in these areas, policy and practice appears to have advanced without research evidence. For example, in the case of intermediate care services, the dearth of peer-reviewed publications is surprising. Even within the health-care sector where there is a stronger tradition of evidence-based policy and practice, developments in intermediate care have been viewed as lacking an evidence base (Vetter 2005). Although the national *ex post* evaluation of intermediate care has now reported (Intermediate Care National Evaluation Team 2006), questions remain over the relative cost effectiveness of the different forms, functions and processes of intermediate care (of which there are many), and for different types of service user.

This review suggests that there is a general need for higher quality and fuller methodological reporting of studies of the social care for older people. If evidence-based practice and policy is to become a reality in social care for older people, it requires a solid foundation of scientific research, rigorously designed, executed and disseminated, and that addresses an appropriate range of research questions. High-quality research

is required on the structure and process, as well as outcomes of services, reflecting the nature of the subject being investigated and its state of development. We need to know not just what to provide, but how to provide it in such a way that will maximise the benefits for older people. More investment is required in research to determine the effectiveness and cost-effectiveness of: modes of service integration for different groups of older service users, how best to confer the same degree of choice, control and independence afforded to some younger disabled adults through direct payments, and how to commission and organise services around the needs of the individual older person. For the studies to be useful to policy makers, service commissioners and practitioners, they must deliver on the different dimensions of methodological quality assessed in this review, for only then will they constitute a sound evidence base.

The systematic review has also provided baseline information from which to judge the impact of the modernisation of social care for older people. Public-services reform is a continuous process in the UK. With roots in the neo-liberal reforms of the 1980s and 1990s, it continued through a 'radical programme' of reform during the Labour party's third subsequent administration (Blair 2005). For older people's services, the standards set out in the NSFOP continue to be reflected in the 2006 White Paper for community services, *Our Health, Our Care, Our Say* (Cm 6737 2006), whilst new initiatives are in train to promote the integration of health and social care, independence and person-centred care (DH 2007*b*), underpinned by the 'choice' agenda that is applied to many public services. Modernising social care for older people is no small task. Social-care spending runs at £13.8 billion in adult services – older people being the single largest user group and accounting for 44 per cent (Health and Social Care Information Centre 2006). Moreover, increasing financial pressures are inherent in many of the recent modernisation reforms that seek to divert further the care of older people from acute hospitals to the community, *e.g.* intermediate care and the new health and social care model for managing long-term conditions (DH 2005). Without an adequate evidence base, however, policy makers and commissioners will struggle to ensure that service improvements can be made with finite resources.

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NOTES

1 Cm and Cmnd (formerly used) abbreviate Command. United Kingdom government publications presented to Parliament are known as Command Papers. Most but not all Command Papers are published in a numbered series. They include White Papers, government policy initiatives and proposals for legislation, and Green Papers, government consultation documents (see http://www.parliament.uk/about/how/publications/government.cfm).

2 The electronic databases searched were: *Cambridge Scientific Abstracts* (CSA) hosting *Applied Social Sciences and Abstracts* (ASSIA), *Sociological Abstracts and Social Services Abstracts*; *CareData* (produced by the UK National Institute for Social Work); *Cumulative Index to Nursing and Allied Health Literature* (Cinahl); The Cochrane Library; *Health Management Information Consortium* (HMIC); Medline; PsycInfo (produced by the American Psychological Association) and the *Social Science Citation Index* (SSCI).

3 The hand-searched journals were: *British Journal of Social Work, Health and Social Care in the Community, Journal of Social Policy, Journal of Social Work, Social Policy and Administration, Journal of Interprofessional Care, Age and Ageing, Ageing & Society, International Journal of Geriatric Psychiatry*, and *Quality in Ageing*.

4 The bibliographic software package, *Reference Manager v10* was used to organise the references (ISI ResearchSoft 2001).

5 Cronbach's alpha is based on the average correlation between each of the seven items, indicating the extent to which all of the items measure the same dimension (Cronbach 1951).

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***Note*: An asterisk (*) indicates that the paper was included in the systematic review.**

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Address for correspondence:
Sally Jacobs, School of Pharmacy and Pharmaceutical Sciences,
1st floor, Stopford Building, University of Manchester,
Oxford Road, Manchester M13 9PT, UK

Email: sally.jacobs@manchester.ac.uk