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The Role of Adult Social Care in the Prevention of Intensive Health and Care Needs: A Scoping Review

RESEARCH

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ABSTRACT

Context: Despite the strong emphasis on prevention in social care policy, there is a lack of evidence on the effectiveness of preventive social care interventions to delay escalation of intensive care needs.

Objective(s): We reviewed the literature relating to the role of Adult Social Care to prevent escalation of care needs. We aimed to identify mechanisms in service delivery that prevent development of long-term care needs.

Method(s): We used the PRISMA-ScR framework to review papers reporting the (cost) effectiveness of preventative services. Findings were qualitatively synthesised using elements of realist synthesis.

Findings: Thirty-one papers were included covering: integrated care, intermediate care, rehabilitation, post-discharge services, community-based care, and domiciliary care. Overall, we found few studies with conclusive results to inform policy and practice. Moreover, the evidence was mostly concerned with the impact of social care on health care utilisation, with relatively few studies addressing the impact on social care utilisation. There was some preliminary evidence for the effectiveness of multi-faceted support set within the community, and improvements were observed for patients' Quality of Life.

Limitations: The variety of papers we included reflects the complexity of the social care landscape but prevents robust assessment of the impact of services to delay advancing care needs.

Implications: Greater investment in research in this field will help policy makers and families target scarce resources and invest in the most effective prevention services. We emphasise the impact of prevention services can take several years to realise, which must be reflected in research design and social care funding.

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The Care Act (Department of Health, 2014) stipulates the responsibilities of local authorities in England in relation to social care provision. There is a strong emphasis on preventing, reducing, and delaying needs for care and support (Department of Health, 2014). The focus on prevention aids the promotion of well-being and independence, and perhaps most importantly, is vital to meet the future challenges of an ageing population and increasing care needs (Bergman et al., 2013). Data from the Office for National Statistics predicts that the population of pensionable age (67 and over) will increase from 12.3 million in 2018 to 12.8 million in 2028 (rise of 4.1%), and to 15.9 million in 2043 (rise of 29.3%). Furthermore, the proportion of people 85 and over in the UK is projected to almost double in the next 25 years rising from 1.6 million to 3 million (ONS, 2018). Based on population projections, the demand for long-term care for older people with a disability and those who are unable, or have difficulty performing without help, at least one activity of daily living, is projected to increase from 3.5 million to 5.9 million (rise of 67%) between 2015 and 2040, leading to a 159% rise in public expenditure on social services from 7.2 billion in 2015 to 18.7 billion in 2040 (Wittenberg et al., 2018). Wittenberg and colleagues highlight how these findings illustrate the significance of measures to prevent chronic illness, disability, and dependency when people reach old age.

Although the emphasis on prevention has been prominent in social care policy and commissioning over the last two decades (Department of Health, 1998; Department of Health, 2010; HM Government, 2007; Wistow & Lewis, 1997), the Care Act (Department of Health, 2014) was the first to include prevention as a statutory responsibility. The Act also specifies that local authorities must 'ensure the integration of care and support provision, including prevention, with health and health-related services.' In 2016, NHS England in collaboration with local authorities committed to the provision of more integrated health and social care. Across England, integrated care systems (ICSs) were instituted with the aim of uniting care services that hold the collective responsibility of providing improved, joined-up care. In theory, by integrating services, people with care needs receive care that is better tailored to their individual needs, positively affecting their health and well-being outcomes, and reducing need for high-level and long-term health and care intervention. More specifically, current policies and government guidance advocate for a shift in the demand for acute hospital and residential services to support in the community (Department for Health and Social Care, 2019; Office for Health Improvement and Disparities, 2022).

A distinction can be made between primary and secondary prevention. Primary prevention is targeted at individuals who have no current health or care needs and comprises universally targeted interventions to reduce the prevalence of care needs in the population, for example, public health measures. Secondary prevention targets interventions at individuals with low-level care needs who have an increased risk of developing more intensive health or care needs and aims to delay escalation of intensive care needs. Examples of secondary prevention in social care include intermediate care and rapid response teams. Intermediate care services provide free, short-term support to support recovery and increase independence (NICE, 2020). Intermediate care can take place at home, in residential care, or in hospital. Rapid response teams provide services in people's homes to prevent hospital admissions. These teams were introduced as part of the NHS' Long-Term Plan to support the ageing population and people with complex needs.

Despite the emphasis on prevention in social care policy, there is a relative lack of evidence on the effectiveness of preventative social care interventions. In 2006, a King's Fund report, predominantly focussing on cost-effectiveness, corroborated the paucity of research evidence. Although the author concludes that there is qualitative evidence suggesting preventative interventions aimed at maintaining independence are valued by older people, the evidence of the effectiveness of intermediate care is mixed (Curry, 2006). In addition, most evidence pertaining to reducing escalation of health and care needs is derived from health outcome data, such as avoiding hospital admissions, facilitating discharge, and reducing length of stay in hospital (Curry, 2006). Most evidence relating to savings to social care is limited to qualitative data, such as maintaining independence or enhancing daily functioning (Curry, 2006). Decision making described by commissioners is principally guided by political and organisational demands, service-user experience was not accounted for in a significant way. Consequently, the predominantly qualitative evidence relating to social care is often disregarded, despite the value of qualitative research for evidence-based policy making (Giuseppe et al., 2014). This means the type of evidence commissioners use in decision making about preventative care for older people is ambiguous and patchy (Miller et al., 2013).

While the Care Act (Department of Health, 2014) requires local authorities to provide services that prevent escalation of care needs, there are reasons to be circumspect about preventative interventions. Evidence warranting caution mostly derives from the health sector. Firstly, in their report assessing cost-effectiveness in prevention, Vos et al. (2010) conclude that many preventative interventions have poor effectiveness credentials and do not always guarantee value for money. Secondly, adequate quantification and prediction of individual risk is essential for targeted prevention (King's Fund, 2006). Risk prediction refers

to modelling the predicted risks of a specific health or care outcome. Current risk prediction strategies are only moderately successful, making it challenging to effectively target preventive interventions (Adler et al., 2020). Similarly, the identification of target populations is guided by information about what constitutes 'high-risk'. When designing identification strategies, a balance must be struck between efficacy, and ease and affordability (Pentz, 1994). Studies in health care settings also demonstrate that prevention through health promotion can have adverse effects (Gugglberger, 2018), such as an increase in stigmatisation of groups (Powroznik, 2017; Riley et al., 2017) and heightened uncertainty and worry in target populations (Hvas et al., 2005). In other words, with current models of implementation, prevention is not always better than cure (Vos et al., 2010). In addition, factors such as acceptability to stakeholders and feasibility of implementation must be considered. Taken together, these studies demonstrate that designing effective prevention strategies is not straightforward.

It is evident that both national and local systems, as well as implemented legislation envision an important role for social care in the reduction and prevention of intensive health and care needs. It is important to examine how such policies are translated to practice in the form of models and interventions, as well as investigating how effective these are. A recent paper by Verity et al. (2021) reviewing the conceptualisation of prevention in social care suggests that models of prevention in social care are directly copied from public health approaches to prevention. This disregards the complexity of underlying social care issues, which may affect effectiveness. This scoping review will add to the literature by determining the current evidence base examining the effectiveness of social care interventions for the prevention of intensive health and care needs.

We conducted a scoping review to assess the nature and extent of the current evidence base as well as identifying gaps in the literature relating to the role of social care for the prevention of intensive health and care needs (Arksey & O'Malley, 2005; Grant & Booth, 2009). Focusing exclusively on secondary preventative services, we aimed to examine what is known from the literature about how preventive services exclusively supported by social care and those integrated with health and public health services prevent the development of more intensive health and care support and service need and utilisation.

METHODS

For this review, we used the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018). We aimed to map the research evidence on the role of social care services in the prevention of more intensive health and care needs. This review was undertaken as part of the Applied Research Collaboration Kent, Surrey, and Sussex (ARC KSS), a collaboration consisting of a number of member organisations across the Southeast region. This research was identified by social care stakeholders in a prioritisation study carried out by the authors (Keemink et al., 2023).

ELIGIBILITY CRITERIA

The following inclusion criteria were followed:

- Studies reporting the effectiveness of preventative services, commissioned to avoid development of more intensive health and care needs. Services must be solely carried out by social care services, or in integration with health and/or public health services.
- Studies reporting an outcome measure of the development of intensive health and care needs. This could, for example, be operationalised as 'admission avoidance' or 'reduced dependency'.
- Studies published between January 2014 and April 2022 and written in the English language. The starting point of 2014 reflects the introduction of The Care Act (Department of Health, 2014).
- Studies within the context of adult social care. Literature involving children's social services was excluded.

To ensure the identified literature adhered to the criterion of encompassing social care, a definition of social care was sought. For the purpose of this paper, we followed the definition mentioned in McGilton et al. (2018) guided by the World Health Organisation report on Ageing and Health (WHO, 2015: p.231): 'social care addresses the needs associated with performance of the activities of daily living, connection to one's social networks such as family, friends, and community; access to social programs for support in poverty, unemployment, old age, and disability to optimise social protection.' We imposed no restrictions on study design in anticipation of relevant findings deriving from a wide range of study types.

SEARCH STRATEGY

The search strategy was developed by the research team, one of whom has librarian experience. The following databases were searched from 2014 to 2022 to identify relevant literature: SCOPUS, Web of Science, Social Policy and Practice, and International Bibliography of the Social Science. Table 1 presents an overview of the search terms that were used for each database. The number of hits for each search term per database can be found in Appendix 1. Search terms had to occur in the title, abstract or keywords. Articles from non-relevant disciplines were

excluded, for example, robotics or computer science. The final sample of identified documents were exported to Mendeley, and duplicates were removed using Mendeley desktop reference manager (1.19.8) 'check for duplicates' tool, which was manually reviewed by the second reviewer.

SEARCH TERMS
prevention AND "social care"
prevention AND "intermediate care"
prevention AND reablement
prevention AND "community services"
"social care" AND "rapid response"
"social care" AND "secondary prevention"
prevention AND "social care" AND "community care"
prevention AND "social care" AND "community services"
"social care" AND "hospital at home"
"social care" AND "admission avoidance"
"preventive social care"
"social care" AND "long term care needs"
prevention AND "long term care needs"

Table 1 The Search Terms.

Abstracts of the 3068 identified documents were screened by three reviewers (see Figure 1). Initial screening resulted in 144 eligible documents for full-text review, which was carried out by two researchers. A third researcher double reviewed 25% of the sample to increase reliability. The full-text review resulted in a final set of 31 papers. Included studies were double-checked for not being covered by the included systematic reviews and meta-analyses. A data-charting form was jointly developed by two researchers to establish the variables to be extracted from the included articles and to record the reasons for rejection for excluded articles. Main reasons for exclusion comprised: 1) no clear social care service element, 2) no evaluation element, 3) outcome measures unclear or not related to prevention of intensive care needs. For included articles, charting information was selected based on relevancy to the research question. The following information was extracted: authors, date of publication, title, aims, intervention, or service details (including the social care element and potential mechanisms that prevent long term care needs), method (including measures, analysis, and outcomes), participant details, key findings, and country (Table 2). Data were independently extracted by three reviewers, who consulted on progress regularly and changes were made accordingly. When conflicts arose, these were discussed to reach consensus.

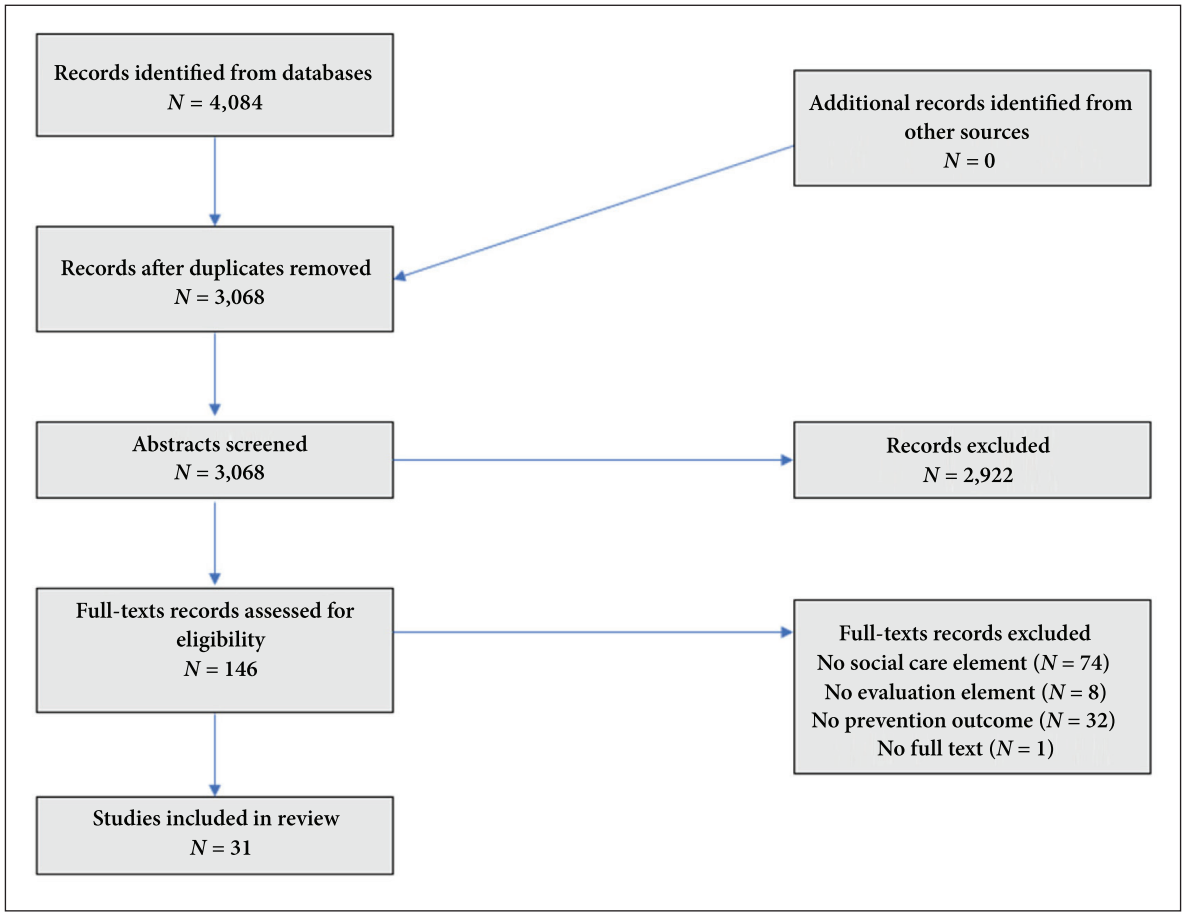

Figure 1 Flowchart of the Scoping Review Screening Process.

AUTHORS/ DOP	TITLE	AIMS	SOCIAL CARE ELEMENT	MECHANISMS/KEY ELEMENTS	MAIN OUTCOMES	MEASURES	SAMPLE	COUNTRY
Integrated Care (*n* = 11)								
Cassarino et al. (2019)	Impact of early assessment and intervention by teams involving health and social care professionals in the emergency department: A systematic review.	To review evidence of the impact of early assessment and intervention by Health and Social Care Professional (HSCP) teams	The HSCP include social care professionals, such as occupational therapists and medical social workers	Comprehensive Functional Assessments, services provided in ED (no detail), coordination and referral to community services, including discharge assessments and post-discharge interventions; **Missing:** unclear from results	Limited evidence for HSCP teams for **Hospital admissions** (2% reduction), **ED revisits, length of stay & mortality rates** (no significant differences found). Good **patient and staff satisfaction**	Systematic review to identify experimental studies examining the effectiveness of HSCP teams for adults >18 in emergency departments.	Six studies (total N = 273,886). All involved care for adults >65	Ireland
Clarke et al. (2020)	The long-term impacts of new care models on hospital use	To examine the impact of Mid-Nottinghamshire's Integrated Care Transformation Programme on hospital use for people over 18	A 24/7 care navigation service, home support service, acute home visiting service, proactive home care service in a care home setting, ambulatory care unit, programme to streamline elective referrals	Regular review by MDTs, self-care hub, care navigation, intensive home support — rehabilitation, medical monitoring, nursing care, acute support at home, services co-located at A&E elective care programmes (e,g., community-based referral services), rapid response and mental health crisis support; **Missing:** unclear which interventions resulted in outcomes due to the range implemented	1) Within 2 to 6 years, **hospital use** decreased by 4.3% for **A&E visits**, 6.7% for **emergency admissions** per 10,000 people p/m compared to a control area, 2) Significant decrease in **hospital admissions for urgent care**, 3) shorter **length of emergency hospital stays**, 4) Lower 30-day emergency admissions	Pre-post comparative study. Measured over 6 years: 1) Rates of A&E visits over 10,000 people p/m, 2) Rates of emergency hospital admissions per 10,000 p/m, 3) number of hospital admissions for urgent care sensitive conditions, 4) length of emergency hospital stays, 5) number of 30-day emergency admissions.	Adult GP population within the Mansfield & Ashfield CCG and Newark & Sherwood CCG	England
Forder et al. (2019)	A system-level evaluation of the Better Care Fund (BCF): final report.	To study how the BCF was used across the country, what people involved thought about the BCF, and to identify evidence that the BCF reduces delayed transfers and emergency admissions	The BCF, a new policy concerning payment for care and services for people that use both NHS and local council social care	Integrated fund shared by NHS and Las funding: assistive technology, 24hr support, assessment & prevention services, well-being services, signposting/care navigation, step-up/down services, reablement, rapid response, Chronic Care Model (CCM); **Missing:** unclear which of the funded integrative services lead to positive outcomes, apart from the CCM/the notion of pooled funds.	Difficult to determine **cost-effectiveness.** Delayed **transfers of care** were negatively related to expenditure pp., with a diminishing effect. Mixed/ weak evidence for reduction in **emergency admissions.** Chronic care model, MDTs/ multiple component strategies showed significant reduction in admissions. Moderate effect of joint interventions on **LoS**.	Economic analysis: amount spent on BCF against number of delayed transfers and emergency admissions. Types of interventions funded by BCF. Measures of the BCF in terms of the sum of activity it supported locally per head of the local population	Over 4000 BCF activities for adults across the country	England

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AUTHORS/ DOP	TITLE	AIMS	SOCIAL CARE ELEMENT	MECHANISMS/KEY ELEMENTS	MAIN OUTCOMES	MEASURES	SAMPLE	COUNTRY
Franse et al. (2018)	The effectiveness of a coordinated preventive care approach for healthy ageing (UHCE) among older persons in five European cities: A pre-post-controlled trial.	To explore the effects of a preventive health and social care approach on the health, quality of life and service use of community-dwelling older persons in five European cities	The Urban Health Centres Europe approach involves a preventive multidimensional health assessment, and targeted care pathways. Client and care worker co-create an individualised care plan	Multidimensional assessment coordinated follow-up care, shared decision making with patient. Interventions included: fall prevention, exercise programmes (home/group), polypharmacy & pharmaceutical care interventions (adherence/ prescribing), social support programmes, and medical action; **Missing:** The most successful sites included regular monitoring by trusted community nurses, with an emphasis on the positive relationship between nurse/SU	No effects of the intervention on **independence or lifestyle factors.** Intervention group had less **recurrent falls and lower frailty** at follow-up**.** Their **HR QOL and mental well-being/loneliness** was significantly better than the control group. No effects on **service use or hospital admissions.** Effects were stronger for specific care pathways	A pre-post-controlled trial comparing intervention participants and controls receiving care as usual. Outcomes taken at baseline and one-year follow-up using a self-report questionnaire assessing healthy lifestyle, fall risk, appropriate medication use, loneliness, frailty, independence, health-related QoL and care use.	1844 community-dwelling older people, aged 70 and over	United Kingdom, Greece, Croatia, Netherlands, Spain
Schapira et al. (2021)	Geriatric co-management and interdisciplinary transitional care reduced hospital readmissions in frail older patients in Argentina: results from a randomized controlled trial	Assess whether geriatrics co-management combined with an interdisciplinary transitional care intervention could reduce hospital readmission rate compared to usual care in frail older patients in a tertiary hospital in Argentina	The intervention arm of the RCT included a geriatric co-management team including social workers. The continuity of care was overseen by a health and social care counsellor and provided in patients' homes	Shared care by medical physician and geriatrician, assessment and treatment by MDT dependent on need and tailored to patient. Daily interactions, regular review and coordination of treatment plans. Transitional care and discharge assessment/ support — connecting hospital care to community care; **Missing:** unclear from results	30-day **hospital (re) admissions** were significantly lower (47.7%) in intervention arm, as well as **emergency room visits** (27.8%) in 6 months after discharge. **Mortality** was lower in the intervention arm; however, the difference with usual care was not significant	Single-blinded RCT: usual care vs. intervention including geriatric co-management combined with an interdisciplinary transitional care team. Outcome measures: 30-day hospital readmissions, emergency room visits, mortality	Frail adults =>75 who had an unplanned hospital admission, with a life expectancy > 6 months. 120 participants in each group	Argentina

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Shepperd et al. (2022)	Hospital at Home admission avoidance with comprehensive geriatric assessment to maintain living at home for people 65 years and over: a RCT	To conduct a robust multisite pragmatic randomised trial and process evaluation, of admission avoidance HAH services with Comprehensive Geriatric Assessments compared with admission to hospital, delivered mostly in specialised elderly care services	The intervention was geriatrician led multidisciplinary admission avoidance HAH. The multidisciplinary team included occupational therapists and access to social care was provided	At-home assessments, MDT liaison, inc. mental health nurses with prescribing capabilities, and social care teams/district nurses. Goal orientated rehabilitation, daily virtual rounds, out of hours care via telephone, and communication with patients and families; **Missing** Familial involvement during assessments, lack of patient involvement re: discharge decisions	No significant difference between intervention/control groups in **independence or mortality** at 6 or 12mo. Participants in the intervention arm were less likely to be **admitted to residential care** and **costs** for Hospital at Home were lower than standard care. **Patient satisfaction** was higher in Hospital at Home arm.	An RCT comparing HAH vs. regular hospital care. Outcome measures: living at home (at 6 mo. Follow-up), incidence of delirium, mortality, new long-term residential care, cognitive impairment, activities of daily living, quality-adjusted survival, hospital admission (6mo). Living at home, new long-term residential care and mortality (12mo)	Frail adults > 65 who required urgent hospital admission. Intervention arm included 700 participants; control arm included 355 participants	England
Sherlaw-Johnson et al. (2018)	Patient-centred care for older people with complex needs: Evaluation of a new care model in outer East London	To examine the implementation of the Health 1000 pilot and its impact on the use of health care resources. Health 1000 is an alternative, registration-based service delivery (carve-out approach)	The Health 1000 provides a multidisciplinary team inc. social workers, key workers and occupational therapists. Care was often delivered at home	Personalised care, proactive case management, review on admission by geriatricians, regular MDT reviews, self-management education, electronic records, key workers with multi-skilled roles; **Missing:** carve-out approach was perceived as costly and created added bureaucracy around prescriptions and integration with other services, lack of home visits	No significant differences in **use of hospital services**. Significantly more primary care contacts in Health 1000. Staff report reduction in unnecessary **outpatient referrals**, and better care continuity. **Staff and patient satisfaction** was high.	Case-control design — 407 patients registered with Health 1000 were matched to a control registered with a local GP. Outcome measures included hospital inpatient visits, attendance at A&E, outpatient appointment, and primary care contacts. Measured after 18 months	407 patients roughly 75 years with complex health needs transferred from their GP to the programme	England
Singh et al. (2022)	Is comprehensive geriatric assessment hospital at home a cost-effective alternative to hospital admission for older people?	To determine the cost-effectiveness of an admission avoidance HAH setting providing comprehensive geriatric assessment compared with hospital admission	Healthcare delivered in the home setting, cutting across primary and secondary care and involving the social care workforce	Geriatrician-led, comprehensive assessment, MDT liaison including social work, rehabilitation, district nursing, MH services, acute hospital services, nurse practitioners, physio, OT, pharmacists. Daily virtual ward rounds; **Missing:** Usual primary care services continued	Comprehensive geriatrics assessment combined with HAH can be **cost-effective** compared to admission. Allocation to the HAH arm resulted in fewer **days in hospital** and reduced **need for residential care.** No difference in **quality adjusted survival**	Cost-effectiveness analysis alongside an RCT of the effectiveness of the intervention. Outcome measures were quality adjusted life years, resource use and costs at baseline and 6 months. Incremental cost-effectiveness ratios were calculated	Participants were =>65. 700 participants in the HAH arm, and 355 participants receiving care in hospital	United Kingdom

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AUTHORS/ DOP	TITLE	AIMS	SOCIAL CARE ELEMENT	MECHANISMS/KEY ELEMENTS	MAIN OUTCOMES	MEASURES	SAMPLE	COUNTRY
Wolfe et al. (2016)	Southwark and Lambeth Integrated Care (SLIC): What we did and how we did it	To examine the impact of Southwark and Lambeth Integrated Care (SLIC), which aims to support local people to lead healthier lives. SLIC is a partnership of health and social care commissioners/ providers	The SLIC programme included holistic assessments, enhanced rapid response, fall prevention, and community multi-disciplinary teams	Simplified discharge, holistic assessments at home, care navigation, community MDTs, information sharing (local care record), telephone self-referral for fall prevention, medical passports (e.g., catheter passport), enhanced rapid response at home, talk helpline (specialist advice for other health workers), discharge to assess (25hr supported environments); **Missing:** Relationships and trust between disparate teams, inflexible assessment	Small reduction in **emergency stays**, whereas this increased for other CCGs. **Care home places** reduced. **Emergency discharges** rose by 2% compared to 23% on average in other CCGs	Cost-effectiveness analysis. At the start of the programme, there was no systematic measurement of the impact of the individual interventions. At the time of the report, this was still being developed. Impact on costs were monitored. No clear details of analysis.	Adults over 65	England
Yu et al. (2020)	Effect of an integrated care model for pre-frail and frail older people living in the community	To evaluate the effect of an integrated care model for pre-frail and frail community-dwelling older people	The intervention was delivered by an integrated team of health and social care professionals	In-depth assessment of health, care and medication needs, personalised care plans, case management focusing on frailty, fall prevention, nutrition, cognitive assessments, coordinated care involving social care providers and health workers; **Missing:** unclear from results	**Frailty** scores significantly improved for the intervention group. No impact on the **use of health services**	Case-control design — Comparison of intervention group and a control group (receiving education on frailty prevention only). Outcome measures: changes in frailty, and use of health services over 12 months	People > 60 assessed as pre-frail or frail. Intervention included 183 patients and 270 control patients	Hong Kong
Lee et al. (2020)	Non-pharmacological interventions to prevent hospital or nursing home admissions among community-dwelling older people with dementia: A systematic review and meta-analysis	To identify effective non-pharmacological interventions to prevent hospital or nursing home admissions among community-dwelling older people with dementia	Non-pharmacological interventions to support people with dementia to stay at home	Common elements of care coordination interventions included initial assessment, individualised care planning, referrals to services, counselling, psychoeducation, regular assessments; **Missing:** direct support to reduce specific ailments, such as falls or dehydration, linkage to community health services	**Nursing home admissions** reduced with care coordination. Single interventions had no effect on **hospital or nursing home admissions**. Successful community care coordination services included (amongst others) initial assessment, individualised care plan, links to community services	A meta-analysis using a random-effect model of identified RCTs in a systematic review. Outcome measures included risk and rate of nursing home/hospital admission	20 studies included, 3,328 older people with dementia, 586 informal caregivers and 1,856 patient-caregiver dyads	World-wide

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Intermediate care (*n* = 6)								
Brown & Howlett (2017)	A critical evaluation of the 'short stay project' — service users' perspectives.	To evaluate the effectiveness of the Short Stay Project, a collaboration between health, housing, and social care in reducing admissions to health and care settings	The short stay project is part of the existing intermediate care provision. It combined reablement with a temporary stay in an adapted, apartment	Physical environment adaptations, support to adjust to changed, telecare, promoting independence; **Missing** psychosocial support, addressing broader social inequalities	Reports of **positive experiences** of the project itself. However, further consideration needed for psychosocial support needs. Patients' health and social care needs not assessed	Interpretative phenomenological analysis exploring service users' lived experience through semi-structured interviews	Three adults aged 30-69, spent =>2 weeks in a project apartment	England
Manning (2016)	A multiple case study of patient journeys in Wales from A&E to a hospital ward or home	To examine the effectiveness of an early response service for admission avoidance	Intermediate care where patients receive care at home from the Early Response Service (ERS) to prevent unnecessary hospital admissions	Access to MDT, rapid access out-patient clinic, community-based care, assessments, referral to support workers; **Missing:** slow hand-over to longer-term care, only 10-days of support	Improvements in the **hospital discharge process** by providing a successful alternative to hospital. Positive impact on **hospital admissions**, saving roughly £60,450 p/m. **Patient satisfaction** was high	A case study design comparing patients who, after attending A&E, either went on to have a hospital stay or went home with ERS support. Data collection methods involved semi-structured interviews with patients and staff	8 women, two men (aged 72-89 yrs., M = 80.5 yrs.)	Wales
NHS Bench-marking Network (2015)	National audit of intermediate care summary report	To assess progress in services that support older people with complex multi-morbidities and high levels of support needs, which aim to maximise independence and reduce hospital use	The audit reviews intermediate care services, which are provided to patients after leaving hospital or when they are at risk of being admitted. Intermediate care services act as a link between different parts of the health and social care system.	Crisis response (<4 hrs response, 48hrs intervention), reablement with involvement of social care professionals, bed-based intermediate care, home-based care provided by MDT, involvement of health professionals; **Missing:** transdisciplinary working, patient-driven care and goal-setting, communication with patients and family, patients request longer duration of support	Majority of service users had improved or maintained **independence**. More than 70% of service users **returned home** after intermediate care. Service users' **experiences** were positive	Pre-post comparative audit of 4 service categories: crisis response, home-based intermediate care, bed-based intermediate care and re-ablement services. Outcome measures: change in dependency, length of stay, intensity of input, destination on discharge. Service user questionnaires were used to gather user experiences	Audit data was provided by 340 services, 53 commissioners. Service user questionnaires were completed by 8,372 older adults	England

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AUTHORS/ DOP	TITLE	AIMS	SOCIAL CARE ELEMENT	MECHANISMS/KEY ELEMENTS	MAIN OUTCOMES	MEASURES	SAMPLE	COUNTRY
NHS Rutt (2014)	Reablement — a review of evidence and example models of delivery	Review the effectiveness and examples of delivery models of reablement services to inform a local delivery model in Yorkshire and Humber	Reablement services, which aim to maximise service users' independence and improve QoL, and includes short-term interventions	Time-limited and outcome-focused reablement involving goal-setting and skills development. Rapid response services, involvement of Ots; **Missing:** lack of a common framework for reablement, focus on well-being/QoL, integration across organisations	Some indication of **cost-effectiveness.** Specifically, some evidence for long-term impact; reduction in **need for social care and health care services**. Inconsistencies in delivery models across the country. Generally, positive **feedback from service users and staff**	Scoping review of reablement services in intermediate care. Methodology and resulting studies not clearly reported	Number and types of included studies not clearly reported	Unclear
McGold-rick et al. (2017)	Befriending and Re-ablement Service: a better alternative in an age of austerity	To evaluate the Befriending and Re-ablement Service (BARS) and its impact on independence and loneliness	BARS is a social care intervention including elements such as befriending and re-ablement	Reablement/befriending, individualised, goal-directed support, skills development, support for informal carers. Delivered by trained and trusted practitioners with local knowledge, home visits, use of the Older Person's Outcomes Star; **Missing:** longer funded period needed	BARS is both a **socially and economically cost-effective** means of enhancing **independent living** among older people, reducing **loneliness and isolation**	Interviews with stakeholders. Assessments used the OPOS (older persons outcomes star) and ASCOT (adult social care outcomes toolkit). Lastly, a cost-benefit analysis.	Adults over 65 years, carers, LA reps. And reps. From Age Concern Liverpool	England
Dowell et al. (2018)	Rapid response: a multiprofessional approach to hospital at home	To provide an overview of patients seen in the rapid response service (RRS) in Gloucestershire and enable an understanding of the effect on hospital admission avoidance and patient outcomes	The RRS involves specialist, coordinated, comprehensive and supportive assessment and treatment 24 hours a day in the patient's own home	24-hr RRS, continuous monitoring according to clinical need, local team working, joined-up working with other disciplines e.g., respiratory teams. Delivered by an MDT, each working holistically dependent on need, enabling transfer of skills across professional boundaries; **Missing:** Difficulties referring to step-down services	The RRS provides **cost savings** compared to acute hospital admission. There was also a reduction in **length of contact** (2.7 days in rapid response vs. 6.9 as inpatient). Overall **satisfaction** of the service was high	Over 5-months, data were collected on the number of patients admitted to the RRS, impact on hospital admission avoidance, patient outcome and patient feedback. Cost data were collected from the trust and compared to costs for acute hospital admission	Over 5 months, 1276 RRS patients. Most >75. Feedback from 105 patients/ relatives. Three case studies	England

(Contd.)

AUTHORS/ DOP	TITLE	AIMS	SOCIAL CARE ELEMENT	MECHANISMS/KEY ELEMENTS	MAIN OUTCOMES	MEASURES	SAMPLE	COUNTRY
Post-discharge services (*n* = 2)								
Coffey et al. (2019)	Interventions to Promote Early Discharge and Avoid Inappropriate Hospital (Re) Admission: A Systematic Review	Review the evidence for interventions in acute hospitals including 1) hospital-patient discharge to home, community services or other settings, 2) hospital discharge to another care setting, and 3) reduction or prevention of inappropriate hospital re(admissions)	Post-discharge services delivered at home	Individualised planning, nurse-led discharge/care, multi-disciplinary management, self-management education, rehabilitation, pharmacological, telecare and follow-up care. Integrated care from health care providers at different levels using multidisciplinary community-based care approach; **Missing:** Hospital costs and resources vary markedly and may influence success of interventions	Pre-discharge planning, education and rehabilitation reduce **readmissions and LoS.** Post-discharge services at home reduced **hospital stay** and impacted positively on **patient satisfaction.** Home-based services impacted positively on readmission for those with chronic conditions. Integrated systems between hospital and community care were most effective in avoiding **inappropriate re-admissions**	Systematic review. Interventions were categorised into 1) pre-discharge exclusively delivered in acute care hospitals, 2) pre- and post-discharge delivered by acute care hospitals, 3) post-discharge delivered at home, and 4) delivered only in a post-acute facility	94 papers were included, age of participants unclear	World-wide
Royal Voluntary Service (2014)	Going home alone: counting the cost to older people and the NHS	To assess the effectiveness and financial impact of HAH services aiming reduce readmissions	HAH services that support recently discharged patients with emotional and practical support on their return home to rebuild confidence and independence	Group-based social support interventions, personalised, co-produced services with elements of reablement, integrated care with community services or volunteers to extend the duration of support; **Missing:** Absence of a control group means it is difficult to determine outcomes without the HAH interventions	HAH services have high **patient satisfaction,** reduce **loneliness and isolation** and seem to reduce the need for **inappropriate readmissions**, while supporting **necessary access to future admissions. Cost-effectiveness** analysis suggests HAH schemes may save the NHS 40.4 million pounds per year	Findings are based on a literature review, stakeholder consultations, a patient survey and a cost-impact analysis based on national data used to model impact. The study focusses on excess costs of hospital readmissions	401 people aged >75 who had spent at least one night in hospital within the past 5 years	England
Community-based care (*n* = 5)								
Bucking-hamshire County Council (2015)	Evaluation of Prevention Matters	To evaluate whether the programme 'Prevention Matters' was cost-effective and brought about intended outcome changes for individuals, organisations, and the wider care system	Prevention Matters is targeted at those whose needs are below the threshold for adult social care and inc. community practice workers in primary care	Assessment and referral to community services, review after 6 months, community links officers to scope community assets, front-line community services offer a range of support (e.g., befriending, lunch clubs), programme leads a volunteer hub; **Missing:** Unclear from results.	**Independence** and **delayed access to social care** services was not always achieved due to the complexity of needs and frailty of service users. **Service user feedback** was positive, with improvements in **mood, social participation, and QoL**. **Cost-effectiveness** not yet achieved over short-term measurement process	Baseline and follow-up data from service users. Qualitative data from workshops with staff, interviews with service users and meetings with stakeholders. Outcomes focussed on increasing/maintaining independence	Baseline and follow-up data from 250 service users, 30 service users over 65 years interviewed	England

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AUTHORS/ DOP	TITLE	AIMS	SOCIAL CARE ELEMENT	MECHANISMS/KEY ELEMENTS	MAIN OUTCOMES	MEASURES	SAMPLE	COUNTRY
Georghiou & Keeble (2019)	Age UK's Personalised Integrated Care Programme (PCIP): Evaluation of impact on hospital activity	To determine whether referral to the PCIP lead to a reduction in hospital activity and reduced cost on health and care systems	The PCIP provides personalised, practical, community-based support, supported by more joint-up health and care services	Tailored services, guided conversations, goal-setting, support planning, MDT support, roughly 3-months provision, development of local health and social care partnerships, shared financial responsibility, joint management framework, co-designed programme; **Missing:** variation in service delivery, identification of unmet health needs resulting in greater service use	No clear benefits found for the PCIP scheme. No evidence of potential **cost savings**, and higher level of **hospital activity** for the PCIP group. The scheme might be identifying unmet needs manifesting in higher hospital use	Comparison of participants of the PCIP scheme and matched controls. Outcomes: commissioning costs, use of emergency/ non-emergency in-patient care, A&E use, outpatient services use after 9 months and for a subset after 16 months (from person-level hospital datasets)	Older people at risk of hospital admission. 1996 participants matched to controls. Mean age 79	England
Harflett & Bown (2020)	CLS Evidence and learning briefings 2020, paper 6a: Learning from local approaches to implementing Community-Led Support in Somerset	To examine the impact of community led support in Somerset on social care use, individual outcomes, costs to adult social care and wider changes.	Community led support is a place-based approach with health and social care services working closely with community partners	Information and advice provision, navigation and links to community services, supporting agency, individualised support, efficient cross-team collaboration, rapid triage; **Missing:** Not clearly addressed	The **cost** of adult social care in Somerset decreased from £78.2 million (2015-16) to £74.9 million (2018-19), reduction in referral for **social care assessments,** reduction in **residential care admissions**, reduction in delayed **transfers of care.**	Analysis methods not listed. Data included: individual outcomes (well-being, physical and mental health, isolation/ social support), costs to and use for adults' social care and other services, and 'wider changes' (e.g., hospital admissions and discharge)	Not clearly mentioned	England
Monitor (2015)	Moving healthcare closer to home: financial impacts	To model the costs of delivering care through schemes that move care currently provided in acute hospitals to community-based settings, compared to delivering care in an acute setting	The examined care schemes include telehealth, enhanced step-up (short-term treatment), rapid response, early supported discharge, and reablement services	Triage by telehealth, care coordination, general advice, MDT assessments, regular virtual ward rounds, avoidance of deconditioning in hospital, regaining skills and confidence, individually tailored goals; **Missing:** All mechanisms are prospective as the paper focuses on modelling. Potentially the challenge of recruiting skilled workforce and building up credibility of the service	**Cost-effectiveness:** in the long term, community-based care schemes that are well-designed to the needs of the local health economy and run efficiently (well-integrated with health services), can provide equal or better care **compared to acute hospital care at lower cost per patient.** Reablement services particularly, which may be run by other parts of the system, can accrue savings to social care	Data collected from hospitals on patients' ICD-10 treatment score, co-occurring conditions, and age. These data were not available for the examined schemes, so high and low case assumptions were established. Data on costs were collected for each scheme. Actual cost impact and comparisons were made using simulation modelling	Adults over 18. The simulation findings apply to a typical suburban local health economy over 5 years	United Kingdom

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AUTHORS/ DOP	TITLE	AIMS	SOCIAL CARE ELEMENT	MECHANISMS/KEY ELEMENTS	MAIN OUTCOMES	MEASURES	SAMPLE	COUNTRY
Orellana et al. (2020)	Day centres for older people: a systematically conducted scoping review of literature about their benefits, purposes and how they are perceived	To review literature reporting the benefits of day centres for older people without dementia. The authors were interested in finding out who benefits and how, the purpose of day centres and how they are perceived	Day centres, which provide a range of programmes and services for older adults, which fall under the social care remit	Social contact & activities, empowerment enabled by relationships, emotional support, management of existing conditions, nutritional support, health promotion activities, integration with health and care services; **Missing:** A lack of reporting on process outcomes and knowledge of elements that prevent LTC needs	Prevention of decline **mental/ physical/cognitive health**, maintenance of general **well-being**, increased **social networks**. Some indication of day centres supporting people to **live at home for longer**	Scoping review of publications about day centres for older people without dementia. The review covered the perceptions, benefits, and purposes of day centres	77 included papers with a diverse range of study types focused on older people	World-wide, mostly US
Domiciliary care (*n* = 5)								
Echevarria et al. (2018)	Home treatment of COPD exacerbation selected by DECAF score: a non-inferiority, randomised controlled trial and economic evaluation	To examine the clinical and cost effectiveness of HAH directed by low-risk DECAF score for patients with an exacerbation of COPD	HAH brings care into patients' own home to avoid hospital admission	Not entirely clear, but potentially daily visits from specialist nurse, remote supervision consultant, daily monitoring of physiological parameters; **Missing:** Not clearly mentioned.	HAH for those with a low DECAF score was more **cost-effective** that usual care, driven by a reduction in **hospital bed days**. No **deaths** for HAH patients and high **patient satisfaction**	Non-inferiority RCT comparing HAH and care as usual, groups were followed for 90 days. Outcome measures: total cost of health and social care, survival, readmission rate, total bed days, cost-effectiveness	Participants aged 35 and over, had low mortality risk, and obstructive spirometry	England
Flemming et al. (2021)	Enhanced home care interventions for community residing adults compared with usual care on health and cost-effectiveness outcomes	To systematically review evidence assessing the cost-effectiveness of alternative programs within home care	Enhanced home care including alternative nursing care, interdisciplinary care coordination, fall prevention, remote monitoring and reablement	Addressing undernutrition, fall prevention**,** telecare, care coordination, alternative nursing, reablement/restorative care; **Missing:** Studies often omitted explicit information about the service provided	Alternative nursing and reablement appeared **cost-effective**. Fall prevention and care coordination appeared to reduce **service use** for subgroups. Mixed results for **HRQoL, physical/mental health, and cognition**. Concerns about inconsistent reporting of data required for economic evaluations	Systematic review of 17 articles grouped into six focus areas: alternative nursing care, fall prevention, interdisciplinary care coordination, telemedicine, reablement, and an undernutrition intervention	Median sample size from all studies was 148 (range = 46–1376). The median participant age was 80.5 yrs. (IQR = 8.8)	World-wide

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AUTHORS/ DOP	TITLE	AIMS	SOCIAL CARE ELEMENT	MECHANISMS/KEY ELEMENTS	MAIN OUTCOMES	MEASURES	SAMPLE	COUNTRY
Lewin et al. (2016)	The Home Independence Program with non-health professionals as care managers: an evaluation	To evaluate the impact of the home independence program in which non-health professionals were trained to be care managers on individual outcomes and health/home care use	The Home Independence Program was carried out by community-based care coordinators	Comprehensive multidimensional assessment, MDT support, goal-oriented care planning, self-management education, promoting sense of autonomy, personalised support, enough time between staff and client; **Missing:** Not clearly described	Gains in all personal outcome measures observed at short- and long-term measurement: **daily functioning, QOL, independence, fall efficacy, service use**. Reductions in service use observed at 6 and 12 months: fewer **deaths, hospitalisations and transfers to residential care.** Small proportion of clients had an increase in homecare. A greater proportion of clients had a **reduction in homecare** or had no further need	Pre-post comparative study. Outcome data collected at baseline, 3 months and 1 year. Outcome measures: activities of daily living, quality of life, falls, service activity Changes over time were tracked, as well as making comparisons with data from a previous RCT, using t-tests.	70 adult participants referred to an assessment for home care	Australia
Mayo-Wilson et al. (2014)	Preventive Home Visits for Mortality, Morbidity, and Institutionalization in Older Adults: A Systematic review and meta-analysis	To conduct a systematic review and meta-analysis on the effectiveness of preventive home visits for community-dwelling older adults without dementia	Domiciliary care visits from health and/or social care professionals	Potentially: support to establish fall reduction, intervention compliance, first-hand assessment of patient's environment, increasing autonomy, reducing physical decline, multidimensional assessment, individualised care plans comprehensively considering needs from different perspectives, collaboration between services; **Missing:** Not clearly described	No high-quality evidence found that home visits reduce **mortality, hospital or residential care admission, falls, independence.** Low quality evidence for improvements to **QoL** and **physical functioning**. There is a possibility that some intervention has meaningful benefits. Poor reporting prevents more robust conclusions	Meta-analysis which evaluated home-visits for community-dwelling older adults. Outcome measures: mortality, institutionalisation, hospitalisation, falls, injuries, physical functioning, cognitive functioning, QoL, psychiatric illness	70 adult participants referred to an assessment for home care	World-wide, mostly USA, UK, and Canada
Sempé et al. (2019)	Multidisciplinary interventions for reducing the avoidable displacement from home of frail older people: a systematic review	Synthesise existing literature on interventions addressing a new concept of avoidable displacement from home for older people with multimorbidity or frailty and to categorise interventions to inform policy	Home-based interventions by any type of multi-disciplinary team, which aim to reduce avoidable displacement from home to hospital settings	MDTs, comprehensive assessments, individualised care plans developed in consultation with patient/family/health professionals, telephone education/assessment, short home visits, referrals; **Missing:** lack of integration, lack of personalisation, interventions that are too short	Mixed evidence for the impact on **readmission**. Several findings not presented. Some evidence **high expenditure and others evidence cost savings.** The available evidence is not sufficiently robust to inform policy or interventions for reducing avoidable displacement from home. This finding reflects the complexity of these interventions and a lack of systematic data collection	A systematic search was conducted to identify studies relating to interventions addressing avoidable displacement from home for older people.	15 included papers with participants over 60	World-wide

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AUTHORS/ DOP	TITLE	AIMS	SOCIAL CARE ELEMENT	MECHANISMS/KEY ELEMENTS	MAIN OUTCOMES	MEASURES	SAMPLE	COUNTRY
Rehabilitation services (*n* = 2)								
Meisingset et al. (2021)	Patient characteristics and outcome in three different working models of home-based rehabilitation: a longitudinal observational study in primary health care in Norway	To compare patients' characteristics and treatment outcomes in three working models of home-based rehabilitation	The focus is on home-based rehabilitation. The three treatment models include: early intervention, reablement and regular physiotherapy	Collaboration between therapist and patient, minimising physical decline, promoting independence, multidisciplinary approach, timeliness; **Missing** complex health needs, reduced cognitive function, language barriers	All models increased **physical function**. Regular physiotherapy and reablement also led to improved **physical performance and HR QOL.** Early intervention identified patients at risk of functional decline at an earlier stage compared to reablement/ physiotherapy. However, there already differences between participant groups at baseline	Pre-post comparative study. Physical function, physical performance, and health related QOL were assessed at baseline and follow-up (max 6 months apart). Participants were assigned to a treatment model by health care professionals based on their functionning and level of independence	Older adults (=>65) at risk of functional decline referred for home-based physio. 603 at baseline and 402 at follow-up	Norway
Rabiee et al. (2015)	Vision rehabilitation services: what is the evidence? A final report	Provide an overview of the evidence base for community-based vision rehabilitation services for people over the age of 18 with visual impairment	Focus on community-based rehabilitation services funded by local authorities	Group-based, personalised, multidimensional support, high quality assessment, timeliness, access to equipment & specialist skills, involvement of family/ friends; **Missing:** psychosocial support, time pressure on staff, lack of collaboration with external teams, delays in referrals	Scant evidence of **(cost) effectiveness** of community-based vision rehabilitation. Group-based self-management interventions seem promising to positively impact on **daily living activities** and **psychological outcomes,** and feelings of safety, confidence and independence	This article includes a literature review, scoping workshops with professionals, a national survey and case studies with staff and service users	Workshops: 15 staff, 11 service users, 89 survey responses, Focus Groups: 15 staff and 15 service users	England
Mixed service types (*n* = 1)								
Cordis Bright (2019)	Interventions to reduce & manage demand: what do our recent studies tell us?	To compare the outcomes of several recently evaluated interventions aiming to reduce or manage demand for health and care services. To examine whether there are key factors that contribute to success	Comparison of 6 interventions including a support navigator model, enhanced health in care homes, telehealth, and integration of health and social care partners	Six interventions discussed, 1. Improved co-ordination of support, 2. Specialist interventions, 3. Accessibility of health intervention through technology, 4. Risk stratification and multidisciplinary teams, 5. Improved co-ordination of support, 6. Supporting self-management; **Missing:** Not clear	The support navigator model was most successful in reducing **unplanned interventions.** Other interventions showed mixed results or lacked long-term data. **Key factors supporting implementation** include workforce buy-in, strategic planning, integration, co-production and using evidence-based approaches	Pre-post comparative study. Outcome measures varied for different interventions, but focus was on A&E attendance, emergency admissions, length of hospital stay and non-elective admissions. Data collection varied, in some cases on a patient-by-patient basis, other cases aggregate data	Varied per intervention. Focus on people with complex needs and care home residents	UK

Table 2 Date charting table for the final 31 papers included in the review.

Note: HAH — Hospital-at-Home; HR QoL — Health Related Quality of Life; QoL — Quality of Life.

CRITICAL APPRAISAL

Study quality was assessed using the Quality Assessment with Diverse Studies (QuADS) tool (Harrison et al., 2021). The QuADS is a critical appraisal tool designed for reviews including diverse study designs. The QuADS was deemed most appropriate tool for this review due to the inclusion of a diverse set of studies, including economic analyses, systematic reviews, and meta-analyses, and its applicability for health services research (Harrison et al., 2021). The tool requires a rating from 0–3 across 13 domains: theory, aims, setting/population, design, sampling, rationale and appropriateness of data collection tools, procedure, recruitment data, rationale and appropriateness of analysis methods, stakeholder engagement, and limitations. A higher score indicated higher quality of evidence.

Three reviewers independently applied the QuADS criteria to the same subset of studies and discussed their scoring and the applicability of the tool for a range of study types. The three reviewers then appraised 50% of the final papers each. This meant reviewer three appraised 25% each of reviewer one's and reviewer two's papers to ensure agreement. When conflicts arose, the reviewers discussed these until consensus was reached.

ANALYSIS PLAN

The results were qualitatively synthesised with outcomes described according to service or intervention type. We used elements of realist synthesis, including the philosophical approach to data extraction and synthesis (Saul et al., 2013). This involved identifying the Contexts, Mechanisms, and Outcomes of different approaches to help develop an understanding of how certain elements of social care services contribute to the prevention of long-term care needs (Pawson et al., 2004). Adopting a realist approach allowed us to acknowledge the complexity of the international social care landscape, where preventative services are embedded in different social systems and are often developed to work at place.

RESULTS

OVERVIEW OF STUDY CHARACTERISTICS

There is no single definition of preventative activity (Marczak et al., 2019; Tew et al., 2019). However, adult social care provides a range of support services that are considered to have preventative effects. This review focuses exclusively on services offering secondary prevention aimed at reducing or delaying the development of more intensive health and care needs. During the data extraction process, we identified six discrete categories of service type pertaining to secondary prevention. We grouped the final 31 papers by type of service including: Integrated Care (n = 11), Intermediate Care (n = 6), Post-Discharge Services (n = 2), Rehabilitation Services (n = 2), Community-Based Care (n = 5), and Domiciliary Care (n = 5). The interventions pertaining to each service type are discussed separately.

The geographical distribution of the final set of papers can be seen in Table 2. Most were based in the UK or reviewed international evidence. The final set of papers used a range of methodologies, including quantitative methods using pre-post-controlled trials or randomised-controlled trials, reviews and meta-analyses, economic analyses, or a combination of quantitative or qualitative methods (Table 2). We included seven review papers, which contained 15 to 94 studies, with a mean of 50 studies. One review did not report the number of final studies.

Of the 31 papers, 24 reported outcomes relating to older adults. Age thresholds ranged from over 60 to over 75 years. The most common age thresholds were over 65 or over 75 years. In one of these, the inclusion criterion was older people at risk of hospital admission, which resulted in a mean age of 79 years. In another, participants were aged 44–91 years, with most (>90%) aged 65 years and over. Four papers reported their sample as the general adult population, and one reported including participants over 35 years. The age of participants was unclear in the final four studies.

QUALITY OF EVIDENCE

Quality of the identified evidence varied substantially, ranging from a score of 5 to 35 on the QuADS tool (Harrison et al., 2021). The mean score on the QuADS was 25. Table 3 provides an overview of the included papers and their total quality score. We intentionally designed the study to be inclusive of papers varying in quality to reflect the complexity of the relatively underdeveloped social care research field. We therefore note that a low-quality score does not necessarily reflect a lack of utility of the respective paper's findings.

From the thirteen domains of methodological and evidence quality, strengths were found in the *setting/population* and *design* domains. Each domain is given a score from 0–3, with 3 representing the highest score. The *setting/population* domain assesses the extent to which the study provides a clear description of the research setting and target population. Twenty-eight out of 31 studies scored a 2 or 3 on this domain. The *design* domain evaluated whether the study design is appropriate to address the stated research aims. Similarly, 28 out of 31 studies scored a 2 or 3 on this domain.

Papers lacked quality most notably on the *stakeholder involvement* domain, which assesses the evidence that the research considered stakeholders in the design and conduct of the study. In 26 out of 31 studies, there was no mention of stakeholder involvement. Only one study (Wolfe et al., 2016) scored the full 3 points on this domain. As this scoping review included evidence derived from other reviews, the domain *recruitment,* assessing the extent to which recruitment data was described, was not always applicable.

AUTHORS	TOTAL (OUT OF 39)	QUALITY CATEGORY
Harflett & Bown (2020)	5	0–10
Royal Voluntary Service (2014)	12	11–20
Rutt (2014)	12	11–20
Dowell et al. (2018)	18	11–20
Wolfe et al. (2016)	18	11–20
Coffey et al. (2019)	19	11–20
Buckinghamshire County Council (2015)	22	21–30
Lewin et al. (2016)	22	21–30
Yu et al. (2020)	22	21–30
Brown & Howlett (2017)	23	21–30
Echevarria et al. (2018)	23	21–30
Mayo-Wilson et al. (2014)	23	21–30
Sherlaw-Johson et al. (2018)	23	21–30
Monitor (2015)	24	21–30
Sempé et al. (2019)	24	21–30
Singh et al. (2022)	25	21–30
Grant et al. (2014)	27	21–30
Manning (2016)	28	21–30
Georghiou & Keeble (2019)	29	21–30
McGoldrick et al. (2017)	29	21–30
NHS Benchmarking Network (2015)	30	21–30
Orellana et al. (2020)	30	21–30
Schapira et al. (2021)	30	21–30
Den-Ching et al. (2020)	31	31+
Flemming et al. (2021)	31	31+
Franse et al. (2018)	32	31+
Meisingset et al. (2021)	32	31+
Rabiee et al. (2015)	32	31+
Cassarino et al. (2019)	33	31+
Shepperd et al. (2022)	33	31+
Forder et al. (2018)	35	31+

Table 3 Included papers' overall scores on the Quality Assessment with Diverse Studies (QuADS) tool (Harrison et al., 2021) and categorised into four quality categories.

NARRATIVE SYNTHESIS

Integrated care

Integrated care services were the most common service type ($n = 11$). Most were delivered by partner organisations who provided care and support to community-dwelling adults, aiming to prevent hospital (re)admission, support independence and prevent more intensive social care use, and improve Quality of Life (QoL). There is limited evidence for integrated care interventions initiated as the result of hospital admission to reduce further health service use. Cassarino et al.'s (2019) systematic review of six papers found no significant reduction in hospital readmission, length of stay, or mortality when individuals received support from Health and Social Care Professional (HSCP) teams based in emergency departments. However, individuals felt safe upon discharge and there were more referrals to community-based services for specific interventions, such as fall prevention (Cassarino et al., 2019).

One meta-analysis of 20 RCTs evaluated integrated services to support people with Dementia at home (Lee et al., 2020). They found a reduction in more intensive social care use (i.e., new nursing home admissions) when support involved multiple care components, but no effect for single interventions, such as psychoeducation. The remaining six studies revealed potential for integrated care delivered at home or in the community to decrease health and social care service use for adults over 65 without Dementia (Clarke et al., 2020; Forder et al., 2018; Schapira et al., 2021; Shepperd et al., 2022; Singh et al., 2022; Wolfe et al., 2016). Clarke et al. (2020) found a 4.3% and 6.7% reduction for A&E visits and emergency admissions respectively per 10,000 people per month, and shorter emergency hospital stays compared to a control area. Other studies indicate stronger effects for specific care pathways, which use a combination of interventions to address an area of concern, such as fall risk or frailty (Franse et al., 2018), and for interventions addressing chronic health needs or urgent conditions (Clarke et al., 2020; Forder et al., 2018). However, three papers demonstrated no impact on use of hospital services for people without specific or chronic needs (Franse et al., 2018; Sherlaw-Johnson et al., 2018; Yu et al., 2020). While the evidence of reductions in health service use is mixed, studies consistently reported benefits to well-being, reductions in social isolation, and improved Health Related QoL (HRQoL) (Franse et al., 2018; Wolfe et al., 2016; Yu et al., 2020). Overall, satisfaction from people receiving the service was high, and staff reported better continuity of care (Cassarino et al., 2019; Shepperd et al., 2022; Sherlaw-Johnson et al., 2018).

Some economic evaluations suggest integrated Hospital at Home (HAH) interventions can be cost-effective compared with hospital admissions (Shepperd et al., 2020; Singh et al., 2022), while others suggest the evidence for cost savings is limited (Forder et al., 2018; Wolfe et al., 2016). The studies reporting limited evidence of cost-effectiveness represent complex systems involving several initiatives and new ways of working (Forder et al., 2018; Wolfe et al., 2016). Forder et al. (2018) argue complex care systems need time to implement and refine, yet several studies evaluated interventions after just one year (Franse et al., 2018; Sherlaw-Johnson et al., 2018; Yu et al., 2020). Clarke et al. (2020) found reductions in hospital use were mostly observed during the final two years of a six-year evaluation. More time may therefore be needed to fully implement new ways of working and results to be realised.

The complexity and range of integrated care models makes it challenging to identify mechanisms that support positive outcomes. However, multiple component strategies, as opposed to single interventions, appear to have a significant impact on admissions and length of stay (Forder et al., 2018; Lee et al., 2020). While few papers examined admissions to residential care, those that did, found people were less likely to be admitted when interventions included ongoing, holistic assessments at home and involved multidisciplinary teams (MDTs) (Shepperd et al., 2022; Singh et al., 2022; Wolfe et al., 2016). Wolfe et al. (2016) found a 61% reduction in residential care or nursing home admission when people were offered multi-layered support from MDTs. Key elements of integrated services described by the included studies are listed in Table 4. Some papers identified missing elements, which when present may support positive outcomes and reduce health and social care service use. Namely, health services input in the community (Singh et al., 2022; Yu et al., 2020), collaborative working across teams and with the family system, and positive interpersonal relationships between practitioners and care recipients (Franse et al., 2019; Shepperd et al., 2022).

Intermediate care

Papers focusing on intermediate care services (n = 6) examined single interventions including early or rapid response services, bed-based intermediate care, and reablement services, and an audit of the aforementioned intermediate care services in the UK. Early- and rapid-response services typically provide 24-hour or rapid access support at home or in an out-patient clinic. The limited evidence we found suggests community rapid-response services can reduce hospital admissions and are cost-effective and efficient (Dowell et al., 2018; Manning, 2016). Manning (2016) also found rapid-response services can prevent delayed discharge by providing a safe alternative to hospital. A key mechanism in preventing escalation of care needs appears to be the rapid access to MDTs. However, the efficiency of services may be reduced by a difficulty in referring to step-down services, which reflects poor integration between intermediate care and related organisations (Dowell et al., 2018).

Bed-based intermediate care is provided in residential or community services and aims to prevent admission to acute services or long-term care. There is some evidence of improved independence following admission to bed-based services, with over 70% of participants returning home (NHS Benchmarking Network, 2015). While bed-based provision is lower and comes with a higher cost, they provide rapid assessments, have shorter waiting lists (NHS Benchmarking Network, 2015), and receive positive evaluations from care recipients (Brown & Howlett, 2017). However, they can lack psychosocial support (Brown & Howlett, 2017) and participants reported other intermediate services, such as community-based reablement, offer more personalised and higher quality care (NHS Benchmarking Network, 2015). Participants were concerned that gains made in a specialist service would not generalise to their home environments (Brown & Howlett, 2017).

	INTEGRATED CARE	INTERMEDIATE CARE	REHAB.	POST-DISCHARGE	COMMUNITY-BASED CARE	DOMICILIARY CARE
Team members						
MDT involvement	✓	✓	✓	✓	✓	✓
Geriatrician-led care	✓					
Led by/prominent involvement of health professionals	✓	✓		✓	✓	
Pharmaceutical support	✓			✓		
Task-sharing/use of junior team members	✓					
Local/knowledgeable practitioners		✓			✓	
Volunteer involvement				✓	✓	
Joined-up working						
Information sharing and connections between care organisations	✓	✓			✓	
Medical passports	✓					
Integrated funds across care organisations	✓				✓	
Services						
Proactive/rapid-response/24-hour support/crisis response	✓	✓				
Stepped care/discharge to assess	✓					
Emergency department services	✓					
Elective care programmes	✓					
Ambulatory emergency care	✓					
Personalisation						
Personalised care/goal-setting	✓	✓	✓	✓	✓	✓
Shared decision making/ treatment planning with patient and families	✓		✓			✓
Support for informal carers		✓				
Co-designed					✓	
Assessment/monitoring						
Holistic assessments at home	✓	✓	✓			✓
Regular and ongoing assessments	✓		✓		✓	✓
Acute care at home/virtual ward rounds	✓			✓		
Regular monitoring	✓	✓				✓
Daily interactions/support	✓					✓
Care coordination/case management	✓				✓	✓
Transitions						
Transitional care support/ assessments	✓			✓		
Rapid triage					✓	

(Contd.)

	INTEGRATED CARE	INTERMEDIATE CARE	REHAB.	POST-DISCHARGE	COMMUNITY-BASED CARE	DOMICILIARY CARE
Interventions						
Care navigation/referrals/ signposting	✓	✓			✓	
Chronic care support	✓					
Exercise/nutrition support	✓				✓	✓
Patient education					✓	
Self-management support	✓			✓		✓
Rehabilitation/reablement	✓	✓	✓	✓	✓	✓
Mental health support	✓					
Fall prevention	✓					✓
Telecare/ assistive technology	✓	✓	✓	✓	✓	✓
Befriending		✓			✓	
Physical environment adaptations		✓				
Bed-based provision		✓				
Psychosocial support						
Social support/positive relationships w/ practitioners	✓			✓	✓	
Group-based interventions	✓		✓	✓	✓	

Table 4 Mechanisms identified by each service type across the final 31 studies, which may contribute to preventing escalation of long-term care needs.

Reablement services are time-limited models supporting people to recover skills and confidence, and to maximise independence. McGoldrick et al. (2017) found that reablement paired with befriending was socially and economically cost-effective, enhanced independence, and reduced social isolation in older adults. Some evidence indicates that reablement is cost-effective and can reduce long-term health and social care needs (Rutt, 2014). Evidence from bed-based intermediate care suggests reablement activity may be most effective when individuals are supported to adjust to their changed circumstances through personalised, goal-directed support (Brown & Howlett, 2017). It is challenging to identify mechanisms that support positive outcomes as there is no definitive model of reablement (Rutt, 2014), and services are often funded for only short periods, making it difficult to assess the utility in preventing long term health and care needs (McGoldrick et al., 2017). Some suggest outcomes can be influenced by practitioners' local knowledge and in the development of trusted relationships with people receiving care (McGoldrick et al., 2017). Nevertheless, intermediate care services, particularly those provided at home or in the community, receive positive feedback from staff and people receiving care and appear to reduce loneliness and isolation (Dowell et al., 2018; Manning, 2016; McGoldrick et al., 2017; NHS Benchmarking Network, 2015; Rutt, 2014).

REHABILITATION SERVICES

We identified two papers evaluating rehabilitation services, which support people to recover from illness or injury and can include elements of reablement. One paper reviewed the evidence regarding community-based rehabilitation for adults with visual impairment (Rabiee et al., 2015). The authors found considerable variation in implementation, which makes it difficult to assess impact and cost-effectiveness. However, user perspectives were positive, and there was evidence that group-based interventions can have a positive impact on QoL and daily functioning. Rabiee et al.'s (2015) results emphasised a strong link between personalisation of life goals and QoL for adults with visual impairment, despite many vision rehabilitation services focusing on functional domains.

Meisingset et al. (2021) compared three models of home-based rehabilitation for older adults in Norway: early intervention, reablement, and regular physiotherapy. The early intervention group showed improved physical function, whereas physiotherapy and reablement groups showed improved HRQoL, physical performance, and functioning. The early intervention group included people at risk of functional decline, whereas reablement and regular physiotherapy supported adults whose physical functioning had already deteriorated (Meisingset et al., 2021). While the early intervention group showed fewer

significant changes, they had higher baseline scores and made marginal gains in all areas. Meisingset et al.'s (2021) findings demonstrate the value of different types of rehabilitation, but particularly early intervention, in facilitating independence and preventing long term care needs.

POST-DISCHARGE SERVICES

We identified two papers evaluating post-discharge interventions, which support individuals to regain independence following hospital admission. One paper reviewed HAH interventions (Royal Voluntary Service, 2014). When embedded exclusively in the community, they have high satisfaction, can positively benefit QoL, and prevent inappropriate readmissions. Personalised reablement and social support in HAH interventions may facilitate positive outcomes, especially when the duration of support can be extended to meet people's needs (Royal Voluntary Service, 2014). A second paper reviewed post-discharge interventions delivered prior to discharge, both pre- and post-discharge, or post-discharge in the community (Coffey et al., 2019). When they involve education and rehabilitation, pre-discharge services may reduce readmissions and length of stay for readmissions. However, Coffey et al.'s (2019) findings suggest community-based approaches, such as HAH interventions involving MDTs, are the most effective in preventing inappropriate readmissions, particularly for people with chronic conditions, such as COPD.

COMMUNITY-BASED CARE

Community-based care services are typically led by, or delivered in partnership with local communities, including partners in the voluntary, community, business, and public sector. The five papers we found reported mixed results for the effectiveness of community-care services to delay development of intensive care needs. Day centres providing a range of programmes and services appear to prevent cognitive and physical health decline and support the maintenance of well-being (Orellana et al., 2020). Harflett and Brown (2020) evaluated a partnership between voluntary sector organisations and local authority services, which offered community navigation, and social and preventative support through several social enterprises. They found a reduction in the cost of adult social care, fewer social care assessments and residential care admissions, and more people receiving appropriate support at the first point of contact (Harflett & Brown, 2020). Buckinghamshire County Council (2015) and Georghiou and Keeble (2019), however, found no benefits of similar schemes in reducing access to social care, and Georghiou and Keeble (2019) found an increase in hospital activity. Both studies emphasised the potential for community-based schemes to identify unmet needs, particularly for those just below the threshold for adult social care (Buckinghamshire County Council, 2015; Georghiou & Keeble, 2019).

All five papers focusing on community-based care initiatives revealed positive feedback from people receiving care and staff. People receiving community care reported improvements in general well-being, QoL, and reductions in social isolation owing to the greater opportunities for social participation (Buckinghamshire County Council, 2015; Georghiou & Keeble, 2019; Orellana et al., 2020). Harflett and Brown (2020) described an improvement in staff morale, with staff reporting improvements in their work-place self-efficacy, an effect they argued had a knock-on effect in other local authority services. Despite promising findings, Harflett and Brown's (2020) outcomes may not be directly or entirely attributable to the community-based scheme due to other local changes and initiatives at the time, which reaffirms the difficulty in robustly evaluating complex systems of care.

Like integrated and intermediate care services, studies evaluating community-based care services do not evidence cost-effectiveness in the short-term (Buckinghamshire County Council, 2015; Georghiou & Keeble, 2019), but simulation modelling suggests care in the community can be more cost-effective than acute care in the long-term (Monitor, 2015). Monitor (2015) emphasise that to have a positive impact of health and social care use, community-based interventions must be suited to their local health economy and delivered efficiently, reaching recipients in a cost-effective way. We identified some common mechanisms in community-based care interventions that may prevent escalation of care needs, including rapid triage, social and emotional support, functional support in the community and support from MDTs. However, due to the complexity of community-based initiatives, it is difficult to robustly establish which elements support positive outcomes. Table 4 provides a list of potential mechanisms to prevent long-term care needs.

DOMICILIARY CARE

Domiciliary care provides homecare for older adults and can include longer-term nursing care for chronic conditions. We identified five studies evaluating domiciliary care interventions to prevent escalation of health and social care needs. Three papers reviewed the effectiveness of preventative homecare visits for community-dwelling older adults. Mayo-Wilson et al. (2014) found no consistent, high-quality evidence for the effectiveness of homecare visits to support independence, or to prevent health and social care use, falls, or mortality. They found some low-quality evidence for possible improvements to QoL and physical functioning. However, the authors emphasise the poor reporting does not allow clear conclusions of effect (Mayo-Wilson et al., 2014). Similarly, Sempé et al. (2019) identified only

three high-quality papers of 15. One provided robust evidence for a reduction in admissions, and two found no significant differences in hospital admissions compared with a control group (Sempé et al., 2019). Flemming et al. (2021) reviewed alternative models of homecare across speciality areas. Alternative nursing care appeared cost-effective and effectual in supporting health gains and reducing health and social care service use. The authors also highlight the potential for reablement to be a cost-effective and efficacious addition to standard domiciliary care (Flemming et al., 2021). The remaining interventions (fall prevention, care coordination, telecare, and nutrition) had a mixed or neutral impact on HRQoL, physical and mental health, and cognition. However, fall prevention and care coordination appear beneficial for subgroups. Care coordination, for example, was reported as cost-effective and effectual in reducing service use for younger adults with advanced cancer and for stroke patients (Flemming et al., 2021). Flemming et al. (2021) stated that the papers they reviewed often omitted information about the service provided, making it challenging to identify key mechanisms that lead to positive outcomes. Mayo-Wilson et al. (2014) also note that no specific components appeared to distinguish effective home care programmes from ineffective programmes.

The remaining two studies evaluated a Home Independence Programme (HIP) for adults at risk of functional decline (Lewin et al., 2016), and a HAH programme for COPD (Echevarria et al., 2018). The HIP involved MDTs and where each team member (e.g., Occupational Therapists) acted as care managers (Lewin et al., 2016). They found participants made significant gains on personal outcome measures including QoL, independence, daily functioning, and fall efficacy. They argue this led to the reductions in homecare service use, hospitalisation, and transfers to residential care observed at 6 and 12 months. These changes were not significant, which may be attributed to the small sample size (Lewin et al., 2016). Monitor (2015) argued that an effect of preventative interventions on service use can take up to three years to be realised. The trends observed in the HIP after a year may therefore promising for future reductions in service use (Lewin et al., 2016). For COPD patients at risk of admission, home treatment led to a fivefold reduction in days spent in hospital (Echevarria et al., 2018).

DISCUSSION

With this scoping review, we identified 31 studies published after the introduction of the Care Act (Department of Health, 2014), which present evidence on the role of social care services in the prevention of intensive health and care needs. Papers were grouped by service type, including Integrated Care, Intermediate Care, Post-discharge Services, Rehabilitation Services, Community-based Care, and Domiciliary Care. We included a variety of studies in terms of design and quality of evidence presented, which was assessed using the QuADS tool (Harrison et al., 2021). The social care research field is relatively underdeveloped (Rainey et al., 2015; Rutter & Fisher, 2013) explaining the varying degrees of study robustness. Nevertheless, these studies and their results are informative in their context and provide a foundation for further research.

PREVENTING LONG-TERM CARE NEEDS

Our findings present mixed evidence on the effectiveness of the identified social care services for the prevention of long-term care needs. Furthermore, there seems to be a lack of studies using an outcome measure of social care service use relative to studies incorporating an outcome measure of (acute) health services use. This makes it challenging to assess the impact of prevention services on social services use. Nevertheless, for all service types there is some evidence indicating services offered exclusively by, or integrated with, social care could be effective at preventing or delaying long-term care needs. There was consistent evidence for preventative services to benefit people's HRQoL and social connectedness, with satisfaction from people receiving services. Key findings with respect to effectiveness for each service type are summarised below.

Integrated care. Half of the evidence revealed integrated care services have the potential to reduce A&E visits and emergency admissions, aligning with the Care Act's (Department of Health, 2014) emphasis on integrated services. Services appear most effective when they are embedded in the community, involve multiple component strategies and holistic assessments delivered by MDTs, and are appropriately targeted. Use of specific care pathways, which address an area of concern e.g., fall risk or frailty, had a stronger impact on outcomes (Franse et al., 2018).

Intermediate care. There is some high-quality evidence that intermediate care services, especially reablement, can improve independence and are economically and socially cost-effective. Our findings suggest support should be personalised and goal-directed to maximise effectiveness. Rapid-response services also appear to offer a cost-effective means to reduce admissions, which appear to be driven by the rapid access to multi-disciplinary support.

Rehabilitation. There is little research on the effectiveness of rehabilitation. The available evidence suggests that rehabilitation services can improve independence and HRQoL, particularly when involving elements of early intervention and reablement. Personalisation is an important mechanism for effectiveness.

Post-discharge care. Few studies examined post-discharges services. Those that did indicate post-discharge services are effective at reducing hospital readmissions. Targeted services embedded in the community appear effective for people with chronic conditions. For older adults more generally, services including education and rehabilitation appear the most successful when they are offered for a sufficient amount of time.

Community-based care. The evidence for community-based services to prevent escalation of long-term care needs is mixed. Some findings suggest these services successfully serve adults who are just below the threshold for social care. However, this results in a tendency to identify unmet needs, leading to greater use of health and care services. Community-based care can potentially support social participation and prevent cognitive and physical decline.

Domiciliary care. The predominantly low-quality evidence for domiciliary care is mixed regarding its effectiveness for the prevention of long-term care needs. Fall prevention and care coordination appear to be important components for effectiveness for certain subgroups. However, there is little evidence for the effectiveness of domiciliary care to prevent escalation of care-needs. There is some indication that reablement could be a cost-effective addition to domiciliary care, which may improve outcomes.

Although there is high-quality evidence suggesting that certain social care services can support the prevention of long-term care needs in specific contexts, there are also reasons to be cautious about the preventative role of social care interventions. As previous research in health care indicates, it cannot be assumed that prevention is always better than cure (Vos et al., 2010). This review included several medium- to high-quality studies that found a lack of effect of the described preventative intervention on long-term care needs, particularly on hospital use (Buckinghamshire County Council, 2015; Franse et al., 2018; Georghiou & Keeble 2019; Mayo-Wilson et al., 2014; Sherlaw-Johnson et al., 2018; Yu et al., 2020). This reflects the complexity of the question whether social care interventions can prevent long-term care needs and highlights the needs for further high-quality research.

Furthermore, in assessing effectiveness, it might be important to distinguish between system-level outcomes, such as hospital admissions, and personal-level outcomes, such as quality of life, and what outcomes are prioritised in what contexts. Stakeholder input, from both health and care professionals, policymakers, and people receiving services should be considered in this.

COST-EFFECTIVENESS

In addition to establishing the effectiveness of services to reduce or prevent intensive care needs, several publications studied the cost-effectiveness of the preventative services. There is some evidence of cost savings for integrated HAH services (Shepperd et al., 2020; Singh et al., 2022), reablement services (McGoldrick et al., 2017; Rutt, 2014), community care services (Harleftt & Brown, 2020; Monitor, 2015), and domiciliary care services providing specific support (HAH and care coordination) for chronic conditions (Echevarria et al., 2018; Flemming et al., 2021). However, the quality of studies evidencing cost-savings is mixed, and several studies found no robust research demonstrating cost-effectiveness for integrated care services (Forder et al., 2018; Wolfe et al., 2016) or community care services (Buckinghamshire County Council, 2015; Georghiou & Keeble, 2019). Forder et al. (2018) stress the complexity in demonstrating cost-effectiveness for complex care systems like integrated or community-based care services. While more clearly defined interventions, such as HAH, evidence cost-savings in the short-term, there is evidence that care in the community can result in long-term cost-savings (Monitor, 2015).

Most studies did not include measures of cost-effectiveness, which makes it challenging to draw conclusions regarding the relative cost-effectiveness of preventative services. Further complications arise due to challenges in drawing comparisons between studies using different or poorly defined outcome measures (Forder et al., 2018). A 2006 review by the King's Fund presented similar findings, concluding a paucity of quantitative data on the (cost-)effectiveness of preventative services (Curry, 2006). Robust and reliable data on cost-effectiveness is essential for the development and/or endorsement of policy for prevention, which meets the demands of a growing older population with increasing long-term care needs.

CONTEXT

The evidence is underdeveloped in this area and therefore drawing unambiguous conclusions is unwarranted. The evidence that does exist is mixed regarding effectiveness. Some studies show beneficial effects, some do not. This review finding is consistent with the argument that prevention effects are complex and dependent on context. Where possible, we extracted information on the efficacious mechanisms of the preventative interventions. The evidence does provide some indication of the mechanisms that are important and in what way.

Setting. Interventions seem most effective when they are embedded in the community and integrated with wider the health and social care system and stepdown services.

Care recipient. Specific conditions may require specific intervention components. For example, people with dementia may benefit more from multi-layered support compared to single interventions, such as psychoeducation. Services that involve specific care

pathways for areas of concern appear to be most effective.

Delivery. Evidence suggests that preventative intervention should include multiple components, multidisciplinary teams, personalisation, reablement, and social participation to maximise effectiveness.

To fully understand the preventative role of social care interventions, it is essential to identify specific components that work for certain groups in context. This review demonstrated the variety of interventions using a diverse range of components to achieve prevention. However, exact details about the intervention are not always reported. Flemming et al. (2021) stated that the papers they reviewed often omitted information about the service provided, making it challenging to identify key mechanisms that lead to positive outcomes, or to identify elements missing from the interventions. Future evaluations can be small-scale and place-based, reflecting the local and diverse nature of social care services, as long as research designs and outcome measures are robustly developed. Byrne (2013) argues that every complex social intervention should be considered as a 'case', and that systematic comparison across cases is only possible within limits.

Similarly, the operationalisation and implementation of prevention must be considered in each context. A small-scale study by Marczak et al. (2019) looking at how the duty to prevent long-term care needs was translated into effective local practice highlighted that the concept of prevention remains unclear and is interpreted in multiple ways. The evidence for preventative interventions is scarce, making it challenging for local authorities to commission evidence-based practice. Marczak et al. (2019) also found limited evidence for collaboration between adult social care and health services in developing joint prevention strategies. Furthermore, when establishing the impact of an intervention, it is important to consider the length of time required for changes to become apparent. Monitor (2015) argued that an effect of preventative interventions on service use can take up to three years to be realised. New services are often funded for only short periods, making it difficult to assess the utility in preventing long term health and care needs (McGoldrick et al., 2017).

We found a variation of, sometimes poorly defined, outcome measures used by the identified studies, complicating comparisons across studies and impeding clear conclusions about effectiveness. These challenges are echoed by research describing the evaluation of complex interventions. Datta and Petticrew (2013) identified challenges commonly described by researchers evaluating a complex intervention, including content and standardisation of intervention, the organisational context, and the development of outcome measures. More recently, guidelines for reporting complex social interventions have been developed (Hoffman, 2014; Montgomery et al., 2018), however, these are predominantly focussed on medical interventions or randomised controlled trials. Future research, in collaboration with policymakers, could consider the development of social care specific guidelines, or a core outcome set for research on preventative interventions to facilitate comparison across studies and reliable replication of interventions.

STRENGTHS & LIMITATIONS

This review is among the first to provide a comprehensive overview of the evidence regarding the role of social care services for the prevention of long-term care needs. It offers important contextual information in light of the Care Act (Department of Health, 2014) and the emphasis on prevention. We included a variety of studies from both the academic and grey literature, not excluding research based on quality or country.

Nevertheless, this review has some limitations. Firstly, we only included studies that were published after 2014, the publication year of the latest Care Act (Department of Health, 2014). There might be informative evidence published before 2014 that was missed in this review. However, the Care Act (Department of Health, 2014) was the first to include prevention as a statutory responsibility, making an evidence base of much more immediate relevance. Secondly, this review does not, like a meta-analysis, include an analysis of effect sizes, which might be required for robust evidence of effectiveness. However, most of the available evidence does not report effect sizes, and arguably, the evaluation of complex social interventions requires a different approach (Byrne, 2013; Verity et al., 2021). The current review is therefore more appropriate for the type of evidence that is available. Lastly, we could have made more use of stakeholder input for this review, for example to help put the findings into context. Stakeholders were involved in the identification of the research question (Keemink et al., 2023) and will be in the dissemination of findings, but not in conducting the review.

POLICY IMPLICATIONS

The current findings have potential implications for policy development. The Care Act (Department of Health, 2014) made prevention activities a statutory responsibility and the generation of an evidence base is essential for informed decision making on which preventative interventions are (cost-) effective. The mechanisms found in our results firstly suggest interventions that focus on integration between health and care services seem most effective for the prevention of intensive care needs. To increase effectiveness, it is recommended that preventative interventions include multidisciplinary teams, social participation, care coordination, and

personalisation. Secondly, the impact of a preventative intervention make take several years to realise, which needs to be reflected in pilot and trial policy and practice initiatives in field.

This review offers promising evidence for effectiveness and cost effectiveness to be seen in the long-term and warrants investment in preventative interventions. Equally, funding should be made available for research that use longitudinal designs. Local authorities need this evidence to better understand how prevention guidance should be translated to specific interventions. Finally, the emerging evidence for the positive role of social care in the prevention of more intensive care needs could be proposed as an argument for an increase in social care funding. Our findings reveal a potential knock-on effect to NHS service delivery and workforce issues, with much of the cost-savings derived from measures such as hospital admissions and length of stay.

CONCLUSION

This review provides an overview of the current evidence on the role of social care services for the prevention of long-term care needs. Although the evidence is mixed, there is some high-quality evidence suggesting that social care has an important role to play in the prevention of long-term care needs. In particular, integrated services that use a combination of effective components, such as multidisciplinary teams, reablement, and personalisation have the potential to prevent or delay long-term care needs.

Overall, however, this review found few studies with which to inform policy and practice, even given its use of relatively wide inclusion criteria. Moreover, the available evidence was mostly concerned with the effect of social care on health care utilisation, with relatively few studies addressing the question of whether lower intensity social care can prevent the need for more intensive forms of social care, such as nursing home care.

There is, in other words, little evidence to help policy makers and families in how to target scarce resources. An immediate conclusion is that greater investment in research in this field is warranted; even small improvements in care system efficiency as a result of new research would likely be cost effective. In particular, we would recommend an emphasis on the following areas, which are significant gaps in the literature. First, studies that further consider the (final) outcome implications of prevention, especially regarding health and social care integration. Second, studies that provide better evidence of the cost-effectiveness of prevention interventions. Third, research on the differential effects of prevention by care recipient groups and care settings. Fourth, a significant gap to be addressed is the effect of lower intensity social care interventions on the need for more-intensive care in the future (e.g., prevention of care home admission).

More generally, new research could focus on seeking to understand the exact effective components of interventions, as well as further investigation into the specific care recipient groups and contexts that might moderate effectiveness. Finally, it is essential that future research uses rigorous methods, clearly defined outcome measures, and longitudinal designs to ensure that all potential effects are captured.

APPENDIX

SEARCH ENGINE	HITS
SCOPUS	1,010
Web of Science	354
Social Policy and Practice	891
International Bibliography of the Social Science	1,829

Appendix 1 Summary of the searches on four databases and the found results.

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COMPETING INTERESTS

The authors have no competing interests to declare.

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