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The evidence on outcomes of rehabilitation and reablement support: a rapid literature review

Catherine Henderson, Will Byrd, Abokor Mohomed, Gerald Wistow, Jose-Luis Fernandez

Care Policy and Evaluation Centre, LSE

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Glossary of acronyms and initialisms

Acronym	Meaning
ADL	Activities of Daily Living
D2A	Discharge to Assess
EQ-5D	EuroQol Five dimensions
HRQoL	Health-Related Quality of Life
IADL	Instrumental Activities of Daily Living
ICER	Incremental cost-effectiveness ratio
MoRE study	Models of reablement evaluation study
NEADL	Nottingham Extended ADL Scale
OT	Occupational Therapy or Therapist
QALY	Quality-Adjusted Life Year
QoL	Quality of Life
RCT	Randomised Controlled Trial
SCIE	Social Care Institute for Excellence
SCRQoL	Social Care-Related Quality of Life
WHO	World Health Organisation

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Summary

Helping people to regain or maintain their independence is an important aim for NHS and social services. Community-based and transitional services such as reablement and rehabilitation offer a route to meet this aim. These services are often offered to older people experiencing a hospital admission who need support to recover their functional abilities and would benefit from a timely discharge. This population is the target of the 'discharge to assess' model of care. To optimise the effectiveness and cost effectiveness of discharge support models, we need good-quality evidence on the service models available, the populations they serve, their outcomes and their costs. We conducted a rapid review to find recent evidence on outcomes, costs, and cost-effectiveness of rehabilitation and reablement approaches used with populations likely to receive 'discharge to assess' services in the UK.

We searched for literature (such as journal articles and reports) using electronic databases and Google Scholar and screened 2,700 records. We discovered 23 publications reporting results of 19 studies.

There were more studies about reablement than about rehabilitation or intermediate care. These used a broad range of research designs. Designs used in reablement studies were generally less robust than those used in rehabilitation studies, in particular most reablement studies lacked a control group. This meant that evidence of better outcomes for reablement could be attributable to other factors than the reablement intervention.

Rehabilitation models included a community-based in-reach team, bridging hospital and community, and two day-hospital-based services. None of these interventions were found to be associated with better outcomes or lower costs, but neither were they found to be worse or more expensive. There was some evidence that the community-based in-reach rehabilitation service was cost-effective in terms of cost per quality-adjusted life (QALY) compared to a hospital-based rehabilitation service.

Studies using uncontrolled before-after methods to evaluate reablement interventions found that costs of social and/or health care were lower after reablement than before. A modelling study found that homecare reablement was highly likely to reduce costs. An observational study comparing local authorities offering homecare reablement to those offering conventional homecare found that reablement was cost-effective at the NICE £20,000 per QALY threshold.

One intermediate care study examined a comprehensive geriatric assessment hospital at home model. The model was effective in terms of reducing the risk of care home admissions and was cost-effective at the NICE £20,000 per QALY threshold. A scoping review of intermediate care interventions found mixed evidence that intermediate and transitional care could reduce hospitalisation but that combining telephone-based support with coaching could reduce rehospitalisation.

Certain themes appeared across the results of qualitative studies of rehabilitation, reablement and intermediate care interventions: staff working across settings in new ways had concerns about blurred roles and responsibilities. Access to training was particularly important for reablement teams. Inflexibility and lack of personalisation were a problematic feature of many services. Home-based services could be over-focused on essential activities of daily living such as bathing and meal preparation, to the exclusion of valued activities outside the home; and their users' routines could be disrupted by inconveniently timed visits. Nonetheless, in general, interviews with users demonstrated that they valued rehabilitation, reablement and intermediate care services.

Our rapid review had limitations in that screening was mostly carried out by one reviewer; also we used databases that indexed medical, nursing and rehabilitation journal so may have missed grey literature such as reports. However, we did search the SCIE database, which indexes more diverse information sources.

We suggest that future research could address gaps and weaknesses in the evidence base, particularly by adopting strong research designs such as randomised-controlled and controlled trials, strengthening research recruitment and retention efforts, and comparing different restorative models across care settings.

Background

A key objective of care services is to maximise the independence of people with health and social care needs. Often, this objective involves providing community services such as reablement and rehabilitation to help individuals regain their functional ability. This issue is particularly salient for patients discharged from hospital because of the period of recuperation that is often needed post-discharge, and because of the emphasis on community-based care associated with Discharge to Assess models. Good evidence about how reablement and rehabilitation support is configured and targeted and about its effects on outcomes and costs is essential to improve cost-effectiveness in the care system. We conducted a rapid review looking for recent evidence on outcomes, costs, and cost-effectiveness of rehabilitation and reablement approaches used with populations likely to receive 'discharge to assess' services in the UK.

The review scope

Reablement, rehabilitation, and intermediate care approaches overlap to some extent. Both rehabilitation and reablement services fall under the rubric of intermediate care [1]. Intermediate care is largely aimed at the prevention of admissions to either hospital or long-term care and supporting early discharge from hospital. These 'intermediate' services link primary and secondary healthcare and community health and social care. They are typically provided for up to six weeks. A recent consensus statement [2] identified key aspects of intermediate care as including time limits (up to 'several months'), aiming at recovery, restoration of independence or prevention of functional deterioration, providing continuity of care, and working across hospital, long-term care and community settings. People in declining health or function and/or at risk of admission to hospital or care home may be expected to benefit from intermediate care services. It is "best delivered by an interdisciplinary team within an integrated health and social care system where a single point of contact might help to optimise service access, communication and coordination of care"(p.2406).

Rehabilitation encompasses intermediate care models; however compared to intermediate care, its aims are more global, emphasising participation in all areas of life, the contexts in which rehabilitation take place are more diverse (e.g. workplaces) and the duration more extended. The WHO defines rehabilitation as "a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment" [3].

Definitions of reablement vary in their emphasis on goal-planning, person-centredness and scope. SCIE suggests that reablement can occur in home or care home environments, is centred around the person's goals, and requires intensive assessment and intervention for up to six weeks [4]. It focuses on "identifying a person's own strengths and abilities by focusing on what they can safely do instead of what they cannot do anymore." A recent Delphi study produced a definition that covered similar elements (aiming at restoration or maintenance of function, based on initial assessment and reassessment, goal-oriented and person-centred) but also emphasised inclusiveness (e.g. in terms of age and diagnosis), engagement of the person's social network, and aim to 'reduce their need for long-term services' (p. 709) [5]. The authors noted that there was low agreement among UK experts on two elements of the final definition: on delivery 'by a trained and coordinated interdisciplinary team' (p. 715) and on time limits, as the definition excluded mention of time limits to the service. The MORE study [6] suggests a narrower focus for reablement, on activities of daily living:

To restore previous self-care skills and abilities (or re-learn them in new ways) that enable people to be as independent as possible in the everyday activities that make up their daily lives (e.g. cleaning the house, shopping, or bathing and dressing themselves) rather than having someone (e.g. an informal or formal carer) do things 'to' them or 'for' them^{7,8}. (p.3)¹

It seems that rehabilitation and reablement share many attributes; however Metzelthin et al. [5] suggest some differences. The underlying model of care is more medical/hospital-based in rehabilitation and more social model/residence-based in reablement; and reablement has a more explicit objective to reduce use of longer-term services as a result of the intervention.

Objectives of the review

We aimed to carry out a rapid review of the published literature on rehabilitation and reablement, including that reporting on either service type as a form of 'intermediate care'.

It is important that the conclusions of the review are applicable to the population most likely to be users of 'discharge to assess' (D2A)[7]. This model, also known as 'Home first', involves the identification of people who could safely be discharged from acute hospital settings in a timely fashion, following one of four pathways:

- Pathway zero - simple discharge home, for people requiring no new health and social care input, or minimal support
- Pathway 1 – discharge home with a new, increased or restarted health and social care package, for people needing intensive or round-the-clock care (including end-of-life care)

¹ This quotation references two works. Citation [7] is Parker, G., Intermediate Care, Reablement or Something Else? A Research Note About the Challenges of Defining Services. 2014, Social Policy Research Unit: York. Citation [8] is Social Care Institute for Excellence, SCIE Guide 49: Maximising the Potential of Reablement. 2013, Social Care Institute for Excellence: London.

- Pathway 2 – discharge to a round-the-clock residential setting for a short period for people needing recovery, rehabilitation, assessment or planning
- Pathway 3 – discharge to a round-the-clock residential setting for people needing a long-term stay

While many people admitted to acute hospital settings will follow these pathways, some will follow other routes. For instance, those patients with mild-to-moderate disability after a stroke may follow the integrated community stroke service pathways [8].

For this reason, we chose to narrow our definition of rehabilitation to the kinds of rehabilitation services that could be found within non-specialist intermediate care (e.g. avoidance of admission to hospital or care home, integrated care teams, rapid/early supported discharge/hospital at home models), rather than condition-based specialised teams delivering respiratory, stroke, cardiac or hip-fracture rehabilitation. We considered both the SCIE and MORE study definitions of reablement, deeming UK-based reablement to be limited to six weeks, intensive and goal-oriented, but not necessarily led by professionally qualified staff. We did include reablement for people living with dementia, who are more likely to be discharged from acute than from mental health hospitals. We excluded 'adult mental health' reablement, as there are separate 'discharge to assess' pathways from mental health hospitals [9].

Methods

We established inclusion and exclusion criteria based on our definitions as well as other considerations. Evidence was sought reporting effectiveness, costs and cost-effectiveness of rehabilitation and reablement, whether at the individual level or organisational level.

With the 'D2A' population in mind, we were most interested in studies with older people, but as the kinds of services under investigation may not apply strict age cut-offs, we included studies of services targeting adults, as long as the majority of users were older people. We focused on recent evidence, limiting our search to publications from 2010 onwards. Both individual studies and systematic reviews were of interest. Individual studies from any part of the UK were included, as were systematic reviews that included some UK studies. Any form of evaluation, including quantitative and qualitative studies and mixed methods involving individual participants/service users, and systems-level or policy evaluations were of interest. We excluded anecdotal reporting such as overviews/descriptions of services or examples of new or good practice without an evaluative component.

The search strategy was structured using the Eclipse framework [10] (Table 1). An Ovid MEDLINE database search was conducted in early August 2022. Search terms in MEDLINE included strings based on "rehabilitation", "reablement", "intermediate care", "recovery" and terms for allied health professionals (occupational and physiotherapists), terms for functional status (e.g. "activities of daily living", "self care"), duration, community or residential settings, and for the UK [11]. The MEDLINE search was adapted for use in the CINAHL, Cochrane and SCIE databases (see Appendix 1

Search strategies for the complete list of search parameters). In addition, a backwards and forward citation search was conducted in Google Scholar using a key reference on the cost-effectiveness of reablement [12]. The MEDLINE, CINAHL and Cochrane searches were updated again in January 2025, limiting the search to studies published from 1 August 2022 to 31 December 2024. The SCIE search could not be updated, because the database closed down in March 2024. The backwards and forwards citation search was updated in Google Scholar, using the same key reference on the cost-effectiveness of reablement [12].

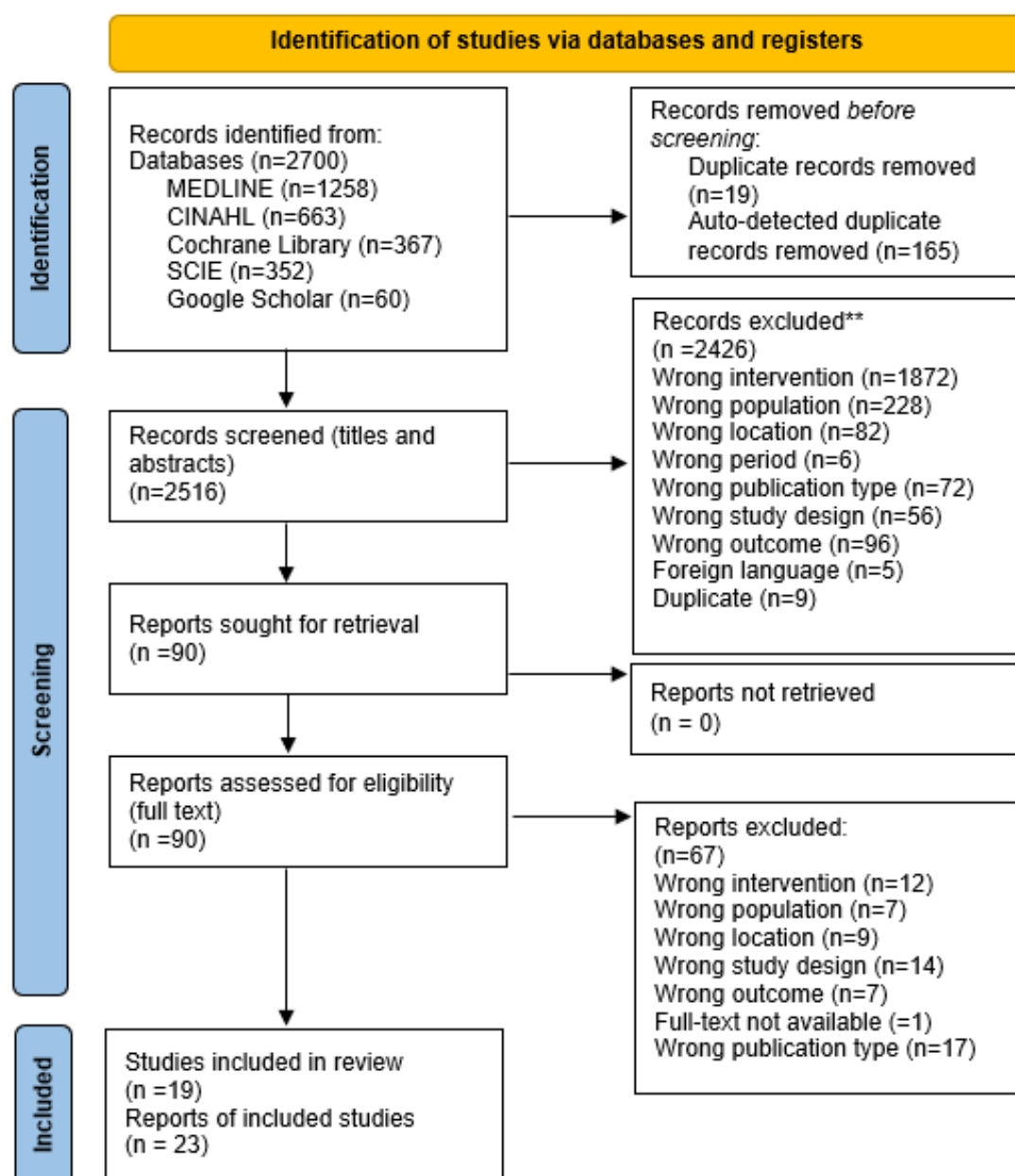
Table 1. Search strategy organised by the ECLIPSE framework

Elements	Defined for our review as	
Expectation	Rapid review of the evidence on rehabilitation and reablement services post-discharge for older adults in UK. What does the evidence tell us about the effectiveness, costs and cost-effectiveness of these services?	
Client group	Older adults with activity limitations who may benefit from either rehabilitation or home-based reablement service in the United Kingdom	
Location	Rehabilitation services	Set in a person's home, a community-based setting/residential/care home setting, or hospitals
	Reablement services	Set in a person's home
Impact	Impact of rehabilitation and reablement services on: <ul style="list-style-type: none"> - Functional status: ADLs, IADLs - Health-related outcomes: QoL/HRQoL - System performance i.e., service utilisation post-intervention, post-hospital admission - Costs of service delivery - Costs to the person/carers 	
Professionals	Local authorities/councils, community and social care staff, multidisciplinary teams (MDTs), health professionals (doctors, nurses) and allied health professionals (e.g. occupational and physical therapists)	
Service	Rehabilitation services	<ul style="list-style-type: none"> - Generalist services (excludes specialist services e.g. cardiac, respiratory, stroke) - Focus on rapid/early supported discharge, integrated care, or avoiding admission to hospital or care home - Longer term (>6 weeks)
	Reablement services	- Time-limited (≤6 weeks) and intensive

Screening of titles and abstracts and subsequent full-text screening were managed in Rayyan [13]. A single reviewer (AM) conducted the initial screening of records from the bibliographic databases; a second (WB) examined a ten-percent sample of these records, conferring with a third (CH) on any potential additional texts for inclusion. Records included for full-text screening were assessed by two reviewers (AM, CH). Data from included publications were extracted by one of the team (AM, WB, CH) using a proforma devised for the review. This covered author, year, country of the UK, type of service (rehabilitation, reablement or intermediate care), type of publication, study design, service design, results

in terms of outcomes, utilisation/costs, cost-effectiveness) and author's statement of limitations.

Figure 1. Search flow



Results

The August 2022 search flow yielded 2,347 records (Figure 1). The January 2025 search flow yielded 353 records. Study characteristics are summarised in Table 2 and further details given in Table A1.1. In total, there were 19 studies reported in 23 publications. The Glendinning 2010 study [14] generated two further articles [15, 16]. The Beresford et al. [17] study generated a report and an article [6], and the Sahota et al. [18] study generated a report and an article [19].

Most studies were carried out with adults over 50 years of age, either by study inclusion criteria [18-26] or de-facto sample composition [6, 14-17, 27-31].

Thirteen studies were located specifically in England, one in Northern Ireland, and one in Scotland. Four studies were located generally in the United Kingdom, while the remaining four studies were either scoping or systematic reviews with no location specified in the inclusion criteria.

Outcome measures used in the quantitative studies included service users' health-related quality of life, social care-related quality of life, ADL function, falls, mental health, delirium and satisfaction with services. Resource use and costs were also measured, for instance in terms of admission to hospital, hospital length of stay, residence in the community or admission to care homes, health and social care service utilisation and costs, and unpaid care provision and costs.

Table 2. Studies included in the review

Study information	Study methods	Service model/description
Intermediate care		
<i>Ariss 2015 [32]</i> , United Kingdom	Qualitative analysis of responses from the 2015 National Audit of Intermediate Care.	Not specified
<i>Sezgin et al. 2020 [24]</i> , Europe, North America, South-East Asia, Western Pacific	Scoping review of the effectiveness of intermediate care interventions, focusing on function, health care use, and costs.	Intermediate care including transitional care interventions and reablement.
<i>Shepperd et al. 2022 [25]</i> , United Kingdom	Multisite RCT open trial comparing comprehensive geriatric assessment hospital-at-home with admission to hospital, with a parallel economic and process evaluation component.	Hospital-at-home (HAH) multidisciplinary teams led by a geriatrician, consisting of medical, nursing and therapy professionals. Health care based on a comprehensive geriatric assessment was delivered in the person's home, seven days a week. HAH could provide acute hospital services e.g. diagnostics and had direct access to hospital admissions.
<i>Trappes-Lomax and Hawton 2012 [31]</i> , England	A qualitative study based on semi-structured interviews using phenomenological analysis.	Participants had received community hospital rehabilitation followed by either discharge home or discharge to short-term rehabilitation in a local-authority residential home
<i>Williams et al. 2018 [28]</i> , England	Analysis of data on community hospital and intensive community support (ICS), in addition to semi-structured care users interviews, and stakeholder interviews and focus groups.	ICS provided support for people with high needs that could not be met by existing services in the community. ICS was staffed by health and social care professionals and support workers. Community hospital service composition was not specified. Both services featured Advanced Nurse Practitioner-led care.
Reablement		
<i>Bauer et al. 2019 [20]</i> , England	Model-based cost-minimisation analysis, comparing reablement and standard home care.	Health and social care team conducting comprehensive multidimensional

Study information	Study methods	Service model/description
		assessment, goal-focused planning and treatment.
Bennett et al. 2022 [26]	Systematic review evaluating randomised controlled trials (RCTs) investigating the population, interventions, who delivered them, the effect and sustainability of outcomes.	Cites Metzelthin et al. [5]: "Reablement is a person-centred, holistic approach that aims to enhance an individual's physical, and or other functioning, to increase or maintain their independence in meaningful activities of daily living at their place of residence, and to reduce their need for long-term services."
<i>Beresford et al. 2019[6],</i> England	Work package (WP) 1 – survey of reablement services. WP2 – observational study of three reablement services. WP3 – staff interviews in eight reablement services.	Study defined reablement as goals-focused, intensive assessment and treatment delivered in the person's residence, time limited (≤ 6 weeks), for people at risk for requiring social support. WP2 sites featured commissioning by the local authority, service provision by teams staffed by private home care providers and/or by in-house local authority reablement workers. Local authority teams were responsible for assessment; whether local authority or private providers had responsibility for monitoring and/or review varied by site. In one site, OT was part of the service.
<i>Beresford et al. 2019[17],</i> England	Prospective cohort study comparing outcomes and resource use in three reablement services.	Three reablement services representing different service delivery models (e.g., including OT, reablement only versus mixed reablement).
<i>Chung 2019 [27],</i> United Kingdom	Semi-structured interviews with individuals who had recently used home care enablement services.	Local authority home care reablement teams included home care workers and supervisors, enablement support workers and OT. OT provided inputs to team on daily basis (e.g. eligibility for social services, OT assessment and treatment).
<i>Ghatorae 2013 [22],</i> Scotland	Longitudinal study examining the impact of reablement by capturing service user and stakeholder views through performance activity data, focus groups, online questionnaires, and interviews.	Not specified
<i>Glendinning et al. 2010[14],</i> England	Comparison of impact and outcomes of reablement with conventional home care, through interviews with service users, senior service managers, carers, focus groups with front-line staff, and collection of quantitative data.	Homecare reablement teams situated in local authority social services departments generally staffed by a manager, team leader, senior support worker and support workers.
<i>Jacobi et al. 2020[23],</i> England	Multilevel logistic regression analysis of management data of reablement episodes to identify neighbourhood and geodemographic predictors of relative reablement success.	Typically the reablement programmes delivered home-based interventions focused on ADL skills or reducing dependency on home care, lasting ≤ 6 weeks.
<i>King and Young 2022[33],</i> England	Semi-structured interviews with two contrasting owners/managers of private domiciliary care agencies .	Reablement is defined as a domiciliary care service of a preventative and short-term nature, focused on encouraging people to do

Study information	Study methods	Service model/description
		their own personal care rather than being dependent on home care.
<i>Legg et al. 2016[34]</i>	A systematic review of RCTs and non-randomised studies, where homecare reablement interventions were compared with no care or usual care.	Definition of homecare reablement involved an intervention of around 6 weeks, typically set in the home or community, staffed by publicly funded health or social care support workers, goal-focused, featuring continual assessment, aimed at improving function in everyday activities including personal care, household and social activities
<i>Rabiee and Glendinning 2011[15], England</i>	Qualitative data were collected through interview with service managers, observations of reablement activities, and focus groups with front-line staff to analyse what influences effectiveness.	Homecare reablement teams staffed by existing home care workers who had received additional training. Services were available for adults aged ≥ 18 years and were usually offered for ≤ 6 weeks but could be provided for longer periods.
<i>Slater and Hasson 2018 [29], Northern Ireland</i>	Retrospective cohort study analysing reablement programme care user records to examine the impact on physical independence, care plans, and care packages post-discharge.	Reablement team within a Health and Social Care Trust, not further specified.
<i>Whitehead et al. 2015[35], unspecified</i>	Systematic review identifying interventions that reduce dependency in activities of daily living in home care service users.	Home care involves ≥ 1 visits per week from a care worker to assist with basic activities of daily living.
<i>Wilde and Glendinning 2012[16], England</i>	Semi-structured interviews with service users exploring experiences of reablement, outcomes, effects on informal carers, and outstanding unmet needs.	See entries for Glendinning et al. 2010 and Rabiee and Glendinning 2011.
Rehabilitation		
<i>Conroy et al. 2010 [21], England</i>	Multicentre RCT of the clinical effectiveness of a day hospital-based falls prevention programme, compared to usual community health and social care.	Participants were identified by a falls screening programme and invited to attend a falls prevention programme situated in a day hospital for older people. Treatments were those used in routine clinical practice and included a medical review, physiotherapy and OT. Intervention and control arms received a falls prevention leaflet.
<i>Parker et al. 2011[30], England</i>	Pragmatic RCT comparing day hospital rehabilitation (DHR) with home-based rehabilitation (HBR).	HBR staffed by all or some of the following workers: hospital doctor, other form of nurse, OT, physiotherapist, social worker, assistant, administrator, other worker. DHR staffed by all or some of the following workers: GP, hospital doctor acute or community hospital nurse, other form of nurse, OT, physiotherapist, social worker, assistant, administrator, other worker.
<i>Sahota et al. 2016[18], England</i>	Pragmatic RCT comparing the effectiveness, microcosts, and cost-effectiveness of the Community In-reach Rehabilitation And Care Transition (CIRACT) service with	CIRACT team included a senior community OT and physiotherapist, assistant practitioner, linking with a social worker. The service included comprehensive assessment, daily visits (including weekends), a pre-discharge home visit, post-discharge follow-up visits.

Study information	Study methods	Service model/description
	traditional hospital-based (THB) rehabilitation.	THB service consisted of an OT and physiotherapist from the hospital rehabilitation services and was available on weekdays. The service included assessment, rehabilitation recommendations, referrals on to community services.
<i>Sahota et al. 2017[19], England</i>	Single-centre pragmatic RCT with a health economic study evaluating the effectiveness and cost-effectiveness of the CIRACT service compared to THB rehabilitation.	See entry for Sahota et al. 2016.

Abbreviations: OT=Occupational Therapist; RCT=Randomised controlled trial

Rehabilitation

Three studies and four publications reported results of rehabilitation interventions. Three publications were randomised controlled trials analysing the effectiveness of the interventions, with either hospital-based rehabilitation [19, 30] or no further intervention [21] as comparators. Sahota et al. [19] formed part of a larger mixed methods study [18] that also included economic analysis and ethnographic research, analysing the effectiveness, micro-costs, and cost-effectiveness of a Community In-reach Rehabilitation and Care Transition (CIRACT) programme, with traditional hospital-based rehabilitation (THB-rehab) as a comparator.

Interventions - service models

Conroy et al. [21] examined a day hospital-based falls prevention programme including a medical review, physiotherapy, and occupation therapy. Parker et al. [30] compared a day hospital to a home-based rehabilitation programme. Sahota et al. [18, 19] evaluated a CIRACT service, joint-funded by health and social services, staffed by a senior occupational therapist and physiotherapist and assistant practitioner, linking with a social worker.

Quantitative or modelling results

Effects

Conroy et al. [21] found no significant difference between the intervention and control arms in the falls rate as a result of the falls prevention programme. However, a low participation rate and incomplete sessions and falls diary entries meant that the trial was underpowered to detect the aimed-for 25% reduction in the rate of falls.

Parker et al. [30] found no significant difference in Nottingham Extended ADL (NEADL) scores between the intervention and control arms during follow-up. The same was true for the EQ-5D, Hospital Anxiety and Depression Scale (HADS), and General Health Questionnaire-30 scores. However, levels of participant ineligibility and refusal led to recruitment below the target sample size.

Sahota et al. [18, 19] found no significant difference between the intervention and control arms in the length of stay, median super spell bed-days, readmission with 28 or 91 days post

discharge, or any of the other secondary outcomes. A number of limitations were recognised in the study, including the sample size, which was only powered to show a large difference in hospital length of stay.

Resource utilisation and costs/cost-effectiveness

Sahota et al. [18, 19] found that the costs to health and social care of CIRACT and THB-Rehab, adjusted for baseline differences, were fairly similar (£3,744 and £3,603 per patient, respectively). The incremental cost-effectiveness ratio (ICER) from a health and social care perspective was £2,022 per QALY and the probability of cost-effective was 91% at a willingness to pay threshold of £30,000 per QALY.

Qualitative results

Effects

Sahota et al. [18] found that the continuity of care offered by the CIRACT service was appreciated by participants and carers. The CIRACT therapists built strong relationships with participants, who subsequently found it difficult to accept the withdrawal of the service despite arrangements to transfer to longer term services. The majority of professional stakeholders regarded the CIRACT service as a positive way of providing care, although some worried about the implications for professional practice of introducing new ways of cross-disciplinary and cross-settings working.

Reablement

Ten studies and thirteen publications reported results of reablement interventions. Out of the thirteen studies, three were mixed methods, four quantitative (including one modelling), four qualitative, and three systematic reviews.

Of the three mixed methods studies, one, by Beresford et al. [6], consisted of three separate work packages. Work package (WP) 1 was a study of the organisational characteristics, delivery, and costs of reablement services. WP2 was a study comparing outcomes and resource use for individuals referred to one of three reablement services, each representing a different service model. WP3 was a study exploring staff experiences in eight reablement services that accepted referrals of people with dementia. A second study, by Glendinning et al. [14], compared the impact and outcomes of home care reablement in five English local authorities with conventional home care service use in five other English local authorities. Both quantitative and qualitative data were collected, including observations of reablement service sites, semi-structured interviews with senior service managers and caregivers, and focus groups with front-line staff. Service users were interviewed at baseline, discharge, and follow-up. Additionally, a cost-effectiveness analysis was conducted. A third study [22] examined experiences and processes of reablement, from the perspective of service users and stakeholders. This used performance activity data, online questionnaires, interviews and focus groups for staff and interviews with service users.

One quantitative study undertook model-based cost-minimisation analysis, comparing two hypothetical cohorts, one receiving reablement, the other, standard home care [20]. A prospective cohort study compared outcomes and resource use of users of three reablement

services [6, 17]. This formed part of the larger mixed methods study [6]. Another study undertook a quantitative analysis of reablement episode data from one English local authority to identify factors constraining and enabling successful reablement [23]. A retrospective cohort study analysed the effectiveness of reablement, where participants' levels of functional ability were examined pre- and post-intervention (Slater and Hasson, 2018) [29].

Three qualitative studies used semi-structured interviews focusing on recent home care reablement service users [16], specifically those living with dementia [27], and owners/managers of private domiciliary care agencies [33]. A final study investigated the content of reablement services and the organisational features that impact on their effectiveness, encompassing observations of reablement work, service manager interviews, and staff focus groups [15].

Of the systematic reviews, two studies examined randomised controlled trials and non-randomised controlled trials, with either no care or usual care as comparators [34] or compared to standard home care [26]. Another examined randomised controlled trials, non-randomised controlled trials, and controlled before-and-after studies of interventions to reduce dependency in activities of daily living (ADL) of users of home care, with routine home care as comparator [35].

Interventions - service typologies

Table 2 sets out descriptions of the interventions examined in the reablement studies.

Some publications describe reablement as multi- or inter-disciplinary and/or goals- or outcomes-focused. Bauer et al. [20] analysed a service model of home care reablement as described by Lewin and Vandermeulen (2010) [36] and Lewin et al. [37], delivered by health and social care workers, involving comprehensive assessment and goal-focused treatment (e.g. restoring ADL functioning, education on accident prevention and self-management strategies, fostering social networks). Beresford et al. [6, 17] defined reablement as having a focus on setting goals and providing intensive assessment and intervention in the person's residence for a maximum of six weeks. Reablement teams in their case study sites featured local authority and private providers' support workers delivering hands-on care. OTs were part of the service in one site. Slater and Hasson [29] examined a reablement team within a Northern Ireland Health and Social Care Trust. Many publications emphasised the short-term nature of the service [6, 14-17, 20, 29]. Beresford et al. [6, 17], Glendinning et al. [14, 15] and Wilde and Glendinning [16] described the purpose of reablement as the restoration of a person's ability to accomplish ADL.

Several studies focused on services explicitly staffed by home care personnel. King and Young [33] defined reablement as a domiciliary care service focusing on encouraging people to do their own personal care rather than being dependent on domiciliary carers. Chung [27] analysed a home care enablement service with daily occupational therapy input. Glendinning et al. [14, 15] and Wilde and Glendinning [16] analysed five local authority reablement services that had evolved from in-house home care services. These reablement teams generally comprised a manager, team leader and support workers.

The Legg et al. [34] systematic review also emphasised the short-term and intensive nature of the service. Whitehead et al. [35] focused on home care studies (home care consisting of one or more care worker visits per week to provide assistance with self-care), five of which concerned homecare reablement services. Bennett applied the Metzelthin et al. [5] definition of reablement.

Quantitative or modelling results

Effects

Beresford et al. [6, 17] found that for health-related quality of life (EQ-5D-5L, EQ-5D VAS), social care quality of life (ASCOT SCT-4), and mental health outcomes (GHQ-12), a significant change in scores was observed at discharge, with improvements in health-related quality of life and mental health maintained at 6 months post-discharge. A significant change in NEADL scores was observed at 6 months post-discharge but not at discharge. A number of limitations were recognised in the study, including challenges with recruitment, which meant that WP2 did not achieve its desired sample size, preventing comparisons between the different models of service delivery. Additionally, there was an absence of comparators, meaning the improvements cannot necessarily be attributed to reablement.

Ghatorae et al. (2013)[22] found that 66 of 181 service users did not need longer-term packages. Those transitioning to mainstream home care had smaller care packages than at the time of hospital discharge.

Glendinning et al. [14] found that home care reablement improved health related quality of life and social care outcomes (on the ASCOT and EQ-5D) of service users compared to conventional home care services.

Jacobi et al. [23] found that 67.7% of reablement care users (excluding those who had died) were classed as able to care for themselves after 13 weeks following the intervention. However, this was a before-after study with no comparator in terms of other/no services. Neighbourhood-level deprivation (on the Index of Multiple Deprivation) was found to have a constraining effect on reablement outcomes.

Slater and Hasson [29] found that care users had significantly improved functional independence measure (FIM) scores post-discharge from reablement. The study referred to a specific geographical context and as a result it is unclear how generalisable the findings are.

Resource utilisation, costs and cost-effectiveness

Bauer et al. [20] found a difference of -£2,061 between reablement and standard care groups (£56,499 vs. £58,560, respectively). There was a 94.5% probability of the reablement intervention reduced health and social care costs. Most of the net benefit (97%) resulted from reduced social care costs, rather than health care costs. However, generalisability of results may not extend beyond models of home care reablement that feature inter-disciplinary teams with goal-focussed treatment planning.

Beresford et al. [6] found that use and costs of some health and social care services declined after reablement compared to pre-baseline, especially hospital admissions. Unpaid care and assistive equipment were in higher use before and over than after the intervention period.

Glendinning et al. [14] found that over 12 months follow-up there were no significant differences in the total costs of either health or social care service use across the two groups. Social care services costs were slightly (£380) lower for home care reablement than conventional home care (£2,430 versus £2,810 respectively, in 2009-2010 prices). At a willingness to pay of £20,000 per QALY, there was a 98% probability of reablement being cost-effective in terms of health and social care costs and a 99% probability in terms of social care costs alone. At a willingness to pay for a gain in social care related quality of life of £20,000, the probability of cost-effectiveness in terms of health and social care costs was 68%, or 98% considering social care costs alone.

Slater and Hasson [29] found that 61.8% of care users exited the reablement programme requiring no services or a reduced care package, with only 10.2% of care users requiring an increased care package.

Qualitative results

Effects

Beresford et al. [6] found that service users expressed satisfaction with reablement. Staff suggested that users and their carers did not understand what reablement was and how it differed from conventional home care, which might have diminished their engagement with the reablement service. Staff offering reablement to people living with dementia considered that the intervention could be useful, but that expectations for the restoration of daily living skills and the time required for delivering the intervention would need to be different for this population than for people not living with dementia. Chung [27] found that home reablement services were critical for supporting care users living with dementia to get back into their usual routines and relieve strain on their carers. Some people living with dementia found that staff did not try to communicate or listen to them about their goals for reablement. Sometimes users and their families seemed to expect that the service would only assist them with regaining basic ADL, not knowing what to expect in terms of support in other life domains.

Ghatorae [22] found that most service users participating in the qualitative research were satisfied with the reablement service. Staff thought that reablement brought benefits such as better cross-organisation working and communication; however they identified problems with duplication of work, inappropriate referrals and blurred professional roles and boundaries. Some elements of the evaluation were affected by low response rates (staff and service user consultations) and scarce time for the research.

Glendinning et al. [14] and Wilde and Glendinning [16] found that while service users and caregivers felt reablement had helped to restore their independence in self-care and food preparation, these services were not helpful in regaining outdoor mobility, nor with re-establishing social connections. Glendinning et al. [14] and Rabiee and Glendinning [15]

report that staff attributed the effectiveness of their service to internal factors (organisation of the service) on the one hand and external factors (organisation of local services) on the other. Internal factors included: staff training and knowledge, assessment and monitoring, and access to assistive equipment. External factors included: clarity among referrers on reablement objectives, access to professional advice (nursing, OT, physiotherapy, mental health teams), and timeliness of transfers to longer term services following reablement. A third factor of importance involved the motivation of the service user to participate. Clarity on the aims and requirements of the reablement service were particularly crucial to the success of reablement, for instance access to specialist advice and appropriate options for follow-on care at the end of the reablement spell.

King and Young [33] found that internal organisational structure interacted with owner or manager's emotional investment in the domiciliary care business to produce a shift from a dependency to a reablement model. External organisational systems such as councils and social services were barriers to adopting a reablement model. Only two participants volunteered for the study, limiting generalisability.

Reviews

Effects

Legg et al. [34] found no randomised controlled or controlled studies evaluating the impacts of reablement on effectiveness in terms of dependence, user or carer quality of life, safety or social participation. Furthermore they questioned the theoretical basis of these interventions. No study limitations were specified by the authors.

Whitehead et al. [35] included 13 studies covering 4,975 participants. Two studies observed statically significant results, where interventions aiming to improve the ability to do ADL independently were more effective than routine home care services. However, these were controlled before-and-after studies assessed as at a high risk of bias. There was also some evidence for improved health-related quality of life. Only Glendinning et al. [14], a mixed methods study also reported here, was focused on an English care setting. A number of limitations were recognised in the included studies, including the risk of methodological bias in the majority of these, and heterogeneity of the population using home care.

Bennett et al. [26] included 8 studies with a total of 1,777 participants aged 65 years and older. The review included one UK study, of 30 participants [38]. The review concluded that reablement was effective, particularly in terms of short-term functional ability at 3 months and longer-term quality of life (6- or 7-month outcomes). Mobility was not improved. Heterogeneity in the way interventions were delivered and in the personnel involved limited generalisability of findings. Five studies had risk of bias limitations.

Resource utilisation, costs and cost-effectiveness

Legg et al. [34] found no data evaluating the impacts of reablement on health and social care resource use. Whitehead et al. [35] found evidence that homecare interventions aiming to improve ability to independently perform ADL could lower utilisation and costs of care services. Bennett et al. [26] found evidence of reductions in need for home care services

based on studies examining this as a primary outcome with low [39] and moderate certainty [40].

Intermediate care

There were five studies that reported on the results of intermediate care interventions. Out of the five studies, there were two mixed methods, two qualitative, and one scoping review.

One mixed methods study by Shepperd et al. [25] involved an RCT of comprehensive geriatric assessment hospital at home (HAH), with admission to hospital as a comparator, combined with economic and process evaluations. The other study consisted of a quantitative analysis of routine data on intensive community support (ICS) provision with community hospital provision as a comparator, accompanied by interviews with service users and focus groups with professional stakeholders [28].

One qualitative study consisted of an analysis undertaken on free-text responses from the 2015 National Audit of Intermediate Care, where data was available for bed-based, home-based, and reablement services [32]. Another study conducted interpretive phenomenological analysis on data from semi-structured face-to-face interviews. Three populations were involved, all who had received initial rehabilitation in community hospitals: those who had spent up to six weeks in a rehabilitation unit attached to a residential home; those who had spent up to six weeks in a local authority stand-alone unit; and those who had gone straight home and received 'usual' community services [31].

One scoping review focused on intermediate care interventions, investigating the effectiveness of intermediate or transitional care interventions on care user functional ability and on use and costs of health and social care [24]. The review grouped interventions into models of: hospital-based transitional care, transitional care at discharge and up to 30 days afterwards, home-based intermediate care and bed-based intermediate care (e.g. in community hospitals, care homes or post-acute facilities).

Interventions - service typologies

Table 2 presents the interventions described in these intermediate care studies. These were diverse, including residential and home-based rehabilitation and reablement services [28, 31, 32] and arrangements including reablement and transitional interventions [24, 25]. Williams et al. [28] examined intensive community support (ICS), featuring Advanced Nurse Practitioner-led care and staffed by health and social care professionals and support workers. Shepperd et al. [25] evaluated a comprehensive geriatric assessment hospital-at-home service, led by a geriatrician and staffed by teams of medical, nursing and therapy professionals with access to acute hospital service. The service was available seven days a week.

Quantitative results

Effects

Shepperd et al. [25] found that there were no significant differences between groups in the proportions of patients 'living at home' or in mortality at 6 and 12 months, or in ability to perform ADL at 6 months. However, there were significant reductions in the risk of living in residential care at 6 and 12 months (relative risks of 0.58 and 0.61 respectively). Patient satisfaction was higher for hospital at home than hospital care.

Williams et al. [28] found that over 5 months of ICS operation, ICS monthly admissions increased by 19% and community hospital monthly admissions reduced by 25%. An imbalance in the source of admissions to community hospital and ICS was noted (88% of admissions to the former were from acute hospital, while 80% of admissions to the latter were from home). Routine data for ICS users did not include demographic or diagnostic information, so that case-mix could not be assessed.

Resource utilisation and costs/cost-effectiveness

Shepperd et al. [25] found mean health and social care and unpaid care costs in the HAH group were £3,017 lower than in the hospital group (£18,437 HAH vs. £21,453 hospital). The probability of cost-effectiveness of HAH was 97% at a willingness to pay of £20,000 per QALY.

Qualitative results

Effects

Ariss [32] analysed the free-text responses of 776 respondents to the question: "Do you feel that there is something that could have made your experience of the service better?" There were more comments relating to ways that the services could be improved (1,158 or 78.6% of 1,474 coded statements) than approvals of the services (316 or 21.4% of statements). Participant responses varied between different types of services. Home-based services were said to be inflexible and terminated too soon, compared to people who had received bed-based and reablement services. All of the service types could be improved by addressing poorly organised transitions and other service coordination issues, and disruptive timing of visits.

Shepperd et al. [25] found that the availability of unpaid carers to provide support (in terms of the home environment, practical help, emotional support) was a crucial condition for delivering HAH. Time and sufficient resources for training were needed for staff to achieve the hospital at home model of multidisciplinary working, while the wider service context could bolster delivery of HAH (if well-coordinated) or impede it (if fragmented or in short supply).

Trappes-Lomax and Hawton [31] found that service users perceived differences between community hospitals and local authority stand-alone residential rehabilitations units, the former helping to improve their mobility and personal care, but the latter particularly suited to getting them to do things for themselves. However both settings could have shown more flexibility and focus on activities important to service users.

Williams et al. [28] found that service users of ICS and community hospitals preferred these services to acute hospital care. Users and staff of both services appreciated the introduction

of Advanced Nurse Practitioner-led care, but staff feedback suggested it had been more successful in delivering community hospital care. Staff felt that ICS patients' needs were less complex than the management had expected.

Reviews

Effects

Sezgin et al. [24] included 133 studies. Evidence was limited on the effectiveness of interventions on care user functioning. Few interventions were targeted towards frail older people.

Resource utilisation, costs and cost-effectiveness

Sezgin et al. [24] found only mixed evidence that intermediate care interventions were associated with reduced hospital admissions and lengths of stay. Evidence was more limited on the cost-effectiveness of interventions. The authors concluded that interventions that include both telephone follow-up and coaching support could reduce rehospitalisation.

Quality as assessed by the studies' authors

Most studies acknowledged some limitations to generalisability or potential for biases. Of RCT studies of rehabilitation, two experienced lower than expected levels of recruitment [21, 30], another [18, 19], limitations in sample size. This reduced the power of the studies to detect outcomes.

Several studies of reablement services deployed a pre-post design either prospectively [6, 14, 17] or retrospectively [23, 29]. Glendinning et al. [14] compared pre-post outcomes of people in a group of local authorities providing reablement compared to an unrandomized control of people in a group of local authorities providing conventional home care. Beresford acknowledged that where improvements were observed, as there was no control group, they could not be attributed with certainty to reablement. Jacobi [23] similarly noted a limitation in attributing the effectiveness results to reablement without a comparison with other forms of care. Glendinning et al. and Beresford et al. [6, 14, 17] acknowledged difficulties with recruitment reducing overall sample sizes. Several studies noted that generalisability of results were limited, either because they had examined a specific model of reablement [20], a specific setting [29] or a specific population (with dementia) [27]. In the Shepperd et al. [25] study, higher missingness related to cognitive impairment was seen in the control group and may have biased estimated differences between groups; however sensitivity analyses investigating the effects of missingness gave similar results. Results were said to be most applicable to the population referred from rapid specialist hospital assessment rather than those referred from primary care. Williams et al. [28] noted that routine data from the intensive community support database lacked detail in terms of demographic information and also had some unstructured clinical data that could not be analysed, hampering examination of the service's case mix. The Ghatorae [22] study of reablement experienced difficulties in recruiting a control group and also the study was unable to conduct planned consultations with unpaid carers. This study also noted a low response rate in the service user and staff consultations.

Of the economic evaluations, the Sahota et al. [18] study conducted micro-costing on the direct costs of the CIRACT and THB-Rehab services but gross costing approaches for estimating the wider NHS and social care costs of the services. The Bauer et al. [20] cost-effectiveness analysis only included reablement, home care, and hospital admission costs and not wider health and care costs such as care home admission. The Glendinning et al. [14] study acknowledged uncertainties about the accuracy of service use and costs data from user self-report and from local authorities.

Of the reviews, the Sezgin et al. [24] scoping review of the effectiveness of intermediate care noted that the interventions studies were heterogeneous, preventing meta-analysis. The Whitehead et al. systematic review [35] noted that when screening studies for the review, it could be difficult to ascertain the characteristics of the users of interventions and the exact nature of the homecare intervention as reported by potential studies.

Discussion

Our rapid review discovered 22 publications reporting results of 18 studies. Most studies examined person-level data, with a wide range of sample sizes. There were five studies of less than 100 cases (2,16,42,44,71), several of between 100 and 1100 cases, and two with over 5000 cases, deploying routine data (Williams et al. [28] and Jacobi et al. [23]), while the systematic reviews covered between 21 and 552,414 cases.

There were marked differences between reablement and rehabilitation studies in terms of study design and also in terms of personnel delivering the intervention services. All rehabilitation studies took the form of (pragmatic) randomised controlled trials, examining interventions delivered by multidisciplinary teams including rehabilitation professionals within inpatient or day hospital services. Reablement studies featured a greater diversity of study design, including prospective and retrospective data analyses. One study featured a comparison between local authorities with homecare reablement services and those with mainstream homecare services. The reablement studies involved diverse data collections, using surveys, quantitative and qualitative primary data collections, but also routine data. Staffing ranged from multidisciplinary teams of health and social care professionals and support workers to teams of support workers without professional qualifications. A small number of studies examined intermediate care interventions, some featuring a mix of rehabilitation and reablement. One consisted of an RCT of a medically-led hospital-at-home service.

In terms of the evidence base on reablement, some evidence of improvements in pre- and post-intervention outcomes (HrQOL, SCrQOL and functional independence) emerged. The weakness of most of these studies was the absence of any control group, making it difficult to attribute results to reablement. One model-based study [16] suggested reablement could secure substantial savings to health and social care. That study adjusted for potential differences in the implementation of reablement services in the UK setting from the originating Australian study. There was also some evidence of interventions being cost-effective, particularly in terms of social care costs. Systematic reviews of reablement studies highlighted the prevalence of weak study designs. One found no studies of robust design (randomised-controlled/controlled trials) to evaluate the effectiveness of reablement

interventions; a second noted that, while two studies observed statically significant results, these were both controlled before-and-after studies assessed as at a high risk of bias. A third review found five of eight included studies to have risk of bias limitations. We found no UK-based randomised-controlled studies, individual-level controlled studies or quasi-experimental studies of reablement, nor any comparisons of reablement services with other service models for instance to hospital-based or community-based day services. There were no studies with data sufficient to compare reablement models to each other (for example homecare reablement versus reablement models that included rehabilitation professionals).

In terms of the evidence for the effectiveness of rehabilitation, it is important to note that we limited inclusion to studies in user populations similar to that of D2A users, i.e. people likely to receive general rather than specialised rehabilitation. Although these studies featured robust study designs, limitations on sample size were a major issue that reduced the power to detect significant outcomes. These studies suggested there was little evidence for the effectiveness of general rehabilitation interventions in hospital or day hospital settings; however, there was some evidence of the interventions being cost-effective.

We located several studies and one scoping review of intermediate care. The interventions described were diverse in terms of the care setting and the personnel involved. A recent RCT suggests that geriatrician-led admission avoidance hospital at home with comprehensive geriatric assessment is cost-reducing. There was some evidence from that RCT that the hospital at home intervention was cost-effective. A study of routine data from two forms of intermediate care, community hospitals and intensive community support (ICS), suggests that the latter may substitute for the former; however the case mix of the services may have been different, with qualitative evidence suggesting that ICS having less complex and dependent users. A recent large-scale scoping review suggested that a combination of telephone follow-up and coaching support could reduce rehospitalisation.

Looking across the results of qualitative studies of rehabilitation, reablement and intermediate care interventions, certain themes are evident. Workers in services that exemplified new ways of working (across settings, or professional boundaries) expressed concerns about blurring of their roles and responsibilities. Access to training was an important factor for a successful reablement service. Reablement teams had issues with referrers from hospital and community not understanding their remit and objectives, resulting in inappropriate referrals. Access to specialist community and hospital services was important for the effective working of intermediate care and reablement teams. The wider health and care system was an important factor in these services' ability to operate optimally. Having long-term services in place for people needing ongoing support after the short-term intervention was important. Unpaid carers played a crucial role in supporting the hospital at home model. People using any of rehabilitation, reablement and intermediate care generally valued these services. However, issues with inflexibility and lack of personalisation arose for service users across these interventions. Home-based services in particular caused disruption for people because of the uncertain or inconvenient timing of visits. Users observed that these services focused on restoring people's ability to carry out basic personal care and domestic tasks to the exclusion of other valued activities outside the home. They sometimes found discontinuation of the short-term services left them with unaddressed needs and feeling lonely or isolated. Goals and expectations of reablement, and duration of service needed to

be different when provided to people living with dementia. People living with dementia were satisfied generally with the support provided by reablement but sometimes had issues with poor communication with reablement workers.

The review has clearly demonstrated gaps and weaknesses in the evidence base. In contrast to the rehabilitation and intermediate care studies employing randomised controlled designs, most reablement studies used weaker designs that were less able to address bias in gauging the effectiveness of an intervention. It is difficult to demonstrate through uncontrolled and non-randomised observational studies that participants' outcomes have been improved by the intervention rather than, for instance, natural recovery over time. Across the prospective rehabilitation and reablement studies, there were smaller than anticipated sample sizes due to recruitment problems. This suggests that different research designs and/or better research recruitment and retention strategies are needed to quantify the effects of these interventions. Lastly, evidence is largely lacking that compares different models of rehabilitation, reablement and intermediate care against each other. For instance, studies could compare outcomes of day centre or day hospital to home-based restorative care models.

Some limitations should be noted. To accommodate the short timescale of the review, screening was mostly carried out by one researcher, with a second researcher reviewing a 10 per-cent sample of search records. The majority of searches were conducted using databases of medical, nursing and rehabilitation journals. It is possible that relevant reports from the grey literature may not have been located because of this strategy. However, we also searched the SCIE database, which indexes a wider range of information sources. Also we conducted a citation search using a key SCIE publication on reablement; this resulted in the location of the Glendinning et al. [14] report, which constitutes a significant element of the reablement evidence base.

Conclusions

This rapid review of evidence on the effectiveness of reablement and rehabilitation from 2010-2024 located 19 studies examining a range of interventions across hospital, residential and community settings. Some of these interventions were defined as 'intermediate care'. Rehabilitation study designs were more robust (randomised-controlled/controlled) than those employed in reablement studies and generated less evidence of effectiveness than did the reablement studies. Further research could address gaps and weaknesses in the evidence base, particularly by adopting strong research designs such as randomised-controlled and controlled trials, strengthening research recruitment and retention efforts, and comparing different restorative models across care settings.

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Appendix 1

Search strategies

MEDLINE SEARCH STRATEGY

1. exp rehabilitation/
2. rehabilitat*.tw.
3. (rehab* or (activit* adj2 daily living)).tw.
4. (intermediate adj3 care).tw.
5. physiotherap*.tw.
6. occupational therapy/
7. (occupational adj3 care).tw.
8. or/1-7
9. reablement.mp.
10. (re abl* or reabl* or enablement or empower* or restor* or re learn* or relearn*).tw.
11. ((recover* or optim* or maintain* or increas* or improv* or independen* or ability or outcome*) adj3 function*).tw.
12. ((enabl* or recover* or maintain* or develop* or living) adj3 independen*).tw.
13. ((recov* or maintain* or relearn* or learn* or regain* or remain* or live or loss or maximise or prolong*) adj3 (function or mobilit* or ability* or confidence or skill* or independent*)).tw.
14. or/9-13
15. "recovery of function"/
16. "activities of daily living"/
17. ((activities adj3 "daily living") or ADL or ADLs or "domestic task*" or "social support" or "personal care").tw.
18. self care/
19. (self adj (care or manag*)).tw.
20. goals/
21. ((support* or assist* or plan* or facilitat* or delay* or early or pre or prevent* or avoid* or scheme*) adj3 (admission* or discharge* or transfer* or model*)).tw.
22. or/15-21
23. (time or intensive or period* or length or brief).tw.
24. ((short or medium or long) adj3 term).tw.
25. 23 or 24
26. housing for the elderly/
27. (hospital adj3 home).tw.
28. (home* adj3 (return* or remain* or care or base* or nursing or health or setting or user* or client*)).tw.
29. ((own or environment or patient* or person or user* or client* or assess*) adj3 (home* or house* or domiciliary or accommodate*)).tw.
30. home care services/
31. intermediate care facilities/
32. (intermediate adj3 (scheme* or service* or setting* or facility* or residen* or home* or hous* or team* or model* or integrated or interdisciplinary or multidisciplinary)).tw.
33. ("community based" adj3 (service* or setting* or environment or health or care or nursing or provision)).tw.
34. community health services/
35. community health nursing/

36. residential facilities/
37. (residential adj3 (facility* or setting* or environment or health or care)).tw.
38. (local adj3 (setting* or environment or house*)).tw.
39. nursing homes/
40. (nursing adj3 (facility* or home* or setting*)).tw.
41. or/26-40
42. exp great britain/
43. (national health service* or nhs*).ti,ab,in.
44. (english not ((published or publication* or translat* or written or language* or speak* or literature or citation*) adj5 english)).ti,ab.
45. (gb or "g.b." or britain* or (british* not "british columbia") or uk or "u.k." or united kingdom* or (england* not "new england") or northern ireland* or northern irish* or scotland* or scottish* or ((wales or "south wales") not "new south wales") or welsh*).ti,ab,jw,in.
46. (bath or "bath's" or (birmingham not alabama*) or ("birmingham's" not alabama*) or bradford or "bradford's" or brighton or "brighton's" or bristol or "bristol's" or carlisle* or "carlisle's" or (cambridge not (massachusetts* or boston* or harvard*)) or ("cambridge's" not (massachusetts* or boston* or harvard*)) or (canterbury not zealand*) or ("canterbury's" not zealand*) or chelmsford or "chelmsford's" or chester or "chester's" or chichester or "chichester's" or coventry or "coventry's" or derby or "derby's" or (durham not (carolina* or nc)) or ("durham's" not (carolina* or nc)) or ely or "ely's" or exeter or "exeter's" or gloucester or "gloucester's" or hereford or "hereford's" or hull or "hull's" or lancaster or "lancaster's" or leeds* or leicester or "leicester's" or (lincoln not nebraska*) or ("lincoln's" not nebraska*) or (liverpool not (new south wales* or nsw)) or ("liverpool's" not (new south wales* or nsw)) or ((london not (ontario* or ont or toronto*)) or ("london's" not (ontario* or ont or toronto*)) or manchester or "manchester's" or (newcastle not (new south wales* or nsw)) or ("newcastle's" not (new south wales* or nsw)) or norwich or "norwich's" or nottingham or "nottingham's" or oxford or "oxford's" or peterborough or "peterborough's" or plymouth or "Plymouth's" or portsmouth or "portsmouth's" or preston or "preston's" or ripon or "ripon's" or salford or "salford's" or salisbury or "salisbury's" or sheffield or "sheffield's" or southampton or "southampton's" or st albans or stoke or "stoke's" or sunderland or "sunderland's" or truro or "truro's" or wakefield or "wakefield's" or wells or westminster or "westminster's" or winchester or "winchester's" or wolverhampton or "wolverhampton's" or (worchester not (massachusetts* or boston* or harvard*)) or ("worchester's" not (massachusetts* or boston* or harvard*)) or (york not ("new york*" or ny or ontario* or ont or toronto*)) or ("york's" not ("new york*" or ny or ontario* or ont or toronto*))))).ti,ab,in.
47. (bangor or "bangor's" or cardiff or "cardiff's" or newport or "newport's" or st asaph or "st asaph's" or st davids or swansea or "swansea's").ti,ab,in.
48. (aberdeen or "aberdeen's" or dundee or "dundee's" or edinburgh or "edinburgh's" or glasgow or "glasgow's" or inverness or (perth not australia*) or ("perth's" not australia*) or stirling or "stirling's").ti,ab,in.
49. (armagh or "armagh's" or belfast or "belfast's" or lisburn or "lisburn's" or londonderry or "londonderry's" or derry or "derry's" or newry or "newry's").ti,ab,in.
50. or/42-49
51. (exp africa/ or exp americas/ or exp antarctic regions/ or exp arctic regions/ or exp asia/ or exp oceania/) not (exp great britain/ or europe/)
52. 50 not 51
53. 8 and 22 and 41
54. 14 and 22 and 25 and 41

- 55. 53 or 54
- 56. exp animals/ not humans.sh.
- 57. 55 not 56
- 58. 52 and 57
- 59. limit 58 to (english language and yr="2010 - 2022")

CINAHL SEARCH STRATEGY (ADAPTED FROM MEDLINE)

- S1. (MH "Rehabilitation")
- S2. TX rehabilitat*
- S3. TX (rehab* or (activit* N3 daily living))
- S4. TX (intermediate N3 care)
- S5. TX physiotherap*
- S6. (MH "occupational therapy")
- S7. (TX (occupational N3 care))
- S8. S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7
- S9. TX reablement
- S10. TX (re abl* or reabl* or enablement or empower* or restor* or re learn* or relearn*)
- S11. TX (recover* or optim* or maintain* or increas* or improv* or independen* or ability or outcome*) N3 function*)
- S12. TX (enabl* or recover* or maintain* or develop* or living) N3 independen*)
- S13. TX ((recov* or maintain* or relearn* or learn* or regain* or remain* or live or loss or maximise or prolong*) N3 (function or mobil* or ability* or confidence or skill* or independent*))
- S14. S9 OR S10 OR S11 OR S12 OR S13
- S15. (MH "recovery of function")
- S16. (MH "activities of daily living")
- S17. TX ((activities N3 "daily living") or ADL or ADLs or "domestic task*" or "social support" or "personal care")
- S18. (MH "self care")
- S19. TX (self N3 (care or manag*))
- S20. (MH "goals")
- S21. TX ((support* or assist* or plan* or facilitat* or delay* or early or pre or prevent* or avoid* or scheme*) N3 (admission* or discharge* or transfer* or model*))
- S22. S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21
- S23. TX ("time or intensive or period* or length or brief")
- S24. TX (("short or medium or long) N3 term")
- S25. S23 OR S24
- S26. (MH "housing for the elderly")
- S27. TX (hospital N3 home)
- S28. TX (home* N3 (return* or remain* or care or base* or nursing or health or setting or user* or client*))
- S29. TX ((own or environment or patient* or person or user* or client* or assess*) N3 (home* or house* or domiciliary or accommodate*))
- S30. (MH "home care services")
- S31. (MH "intermediate care facilities")

S32. TX (intermediate N3 (scheme* or service* or setting* or facility* or residen* or home* or hous* or team* or model* or integrated or interdisciplinary or multidisciplinary))

S33. TX ("community based" N3 (service* or setting* or environment or health or care or nursing or provision))

S34. (MH "community health services")

S35. (MH "community health nursing")

S36. (MH "residential facilities")

S37. TX (residential N3 (facility* or setting* or environment or health or care))

S38. TX (local N3 (setting* or environment or house*))

S39. (MH "nursing homes")

S40. TX (nursing N3 (facility* or home* or setting*))

S41. S26-S40/OR

S42. (MH "Animals+" OR MH "Animal Studies" OR TI animal model*) NOT MH "Human"

S43. S8 and S22 and S41

S44. S14 and S22 and S25 and S41

S45. S43 OR S44

S46. S45 NOT S42

S47. MH united kingdom or uk or britain or scotland or england or wales or northern Ireland

S48. S46 AND S47

S49. S7 AND (Limiters - Published Date: 20100101-20221231; Narrow by SubjectAge: - aged: 65+ years, Narrow by Language: - english)

SCIE SEARCH STRATEGY

Subject Terms:"rehabilitation" including this term only
 OR SubjectTerms:"reablement" including this term only
 AND PublicationYear:'2010 2022'
 AND Location:"united kingdom" including narrower terms]

COCHRANE LIBRARY SEARCH STRATEGY

#1 MeSH descriptor: [Rehabilitation] explode all trees
 #2 (reablement):kw
 #3 re-ablement
 Limits; 2010-2022, Location - UK

Table A1.1. Characteristics of studies included in the review

Study information	Years evaluated	Methodology	Population	Sample size	Comparators
Intermediate care					
<i>Ariss 2015 [32], United Kingdom</i>	2015	Qualitative	Not specified	776 participants across 3 service types: Bed Based, n=302; Home-based, n=298; Reablement Services, n=176.	Bed-based and home-based services
<i>Sezgin et al. [24], Europe, North America, South-East Asia, Western Pacific</i>	2002-2019	Scoping review	Aged over 50 years, with the mean age in studies 50-86.2 years	703,523 participants in the included studies Sample sizes between 21 and 552,414 (in 130 studies)	Not specified
<i>Shepperd et al. 2022 [25], United Kingdom</i>	2014-2020	Mixed methods	Older people who required hospital admission because of an acute change in health (aged over 65 years)	700 participants allocated to HAH, 355 to hospital group. Included in the analyses: HAH n=687, hospital n=345 Qualitative interviews with 34 patients (HAH, n = 15; hospital, n = 19) and 34 caregivers (HAH, n = 16; hospital, n = 18)	Admission to hospital
<i>Trappes-Lomax and Hawton 2012 [31], England</i>	2002-2003	Qualitative	Mean age was 81.4 years	42 participants (mean age 81.4 years)	Three populations: rehabilitation unit attached to a local authority residential home; stand-alone local authority unit; “usual” community services at home
<i>Williams et al. 2018 [28], England</i>	2012-2014	Mixed methods	Both services were designed to serve	5,653 patients admitted to CmH and 1710 to ICS	Community hospital provision for patients

			predominantly older adults	Qualitative interviews with 10 patients; focus groups with 19 staff members.	requiring general rehabilitation
Reablement					
<i>Bauer et al. 2019 [20]</i> , England	N/A	Modelling	The base case model was developed to start when people were aged over 65 years	2 hypothetical cohorts of 1,000 people each: reablement and standard home care	Standard care, personal care at home
<i>Bennett et al. 2022[26]</i>	Prior to August 2021	Systematic Review	All had difficulty completing activities of daily living at home, requiring a home care service. Age, over 65 years, was an inclusion criterion in five studies.	There were 1,777 participants across nine journal articles, reporting eight studies.	Standard home care
<i>Beresford et al. 2019[6]</i> , England	2014-2017	Quantitative	WP1 – the majority of services accepted adults aged over 18 years; WP2 – mean age of participants was 80.8 years; WP3 – services that accepted referrals of people living with dementia	186 from 3 research sites (n=14, n=29, n=139)	WP2 – data were collected on entry into reablement (T0), at discharge (T1), and at 6 months post discharge (T2)
<i>Beresford et al. 2019[17]</i> , England	2016-2017	Mixed methods	Participants had been accepted into one of the reablement services acting as a research site	WP1: 143 reablement services. WP2: 186 individuals recruited to the study: 129 retained at T1, 64 retained at T2. Staff: 20 reablement assessors, 12 reablement workers. Family members:2.	Data were collected at entry to the service (T0), discharge (T1), and 6 months post discharge (T2)

				WP3: 9 services that accepted referrals of people with dementia.	
<i>Chung 2019 [27],</i> United Kingdom	2016-2018	Qualitative	Participants were people living with dementia in their own home, aged 70-90 years	16 participants with dementia, 8 carers	Not specified
<i>Ghatorae 2013 [22],</i> Scotland	2012	Mixed methods	For the performance activity data, 169/181 participants were aged over 65 years; for the service user consultation, 88% in the quantitative section were aged over 66 years and ages in the qualitative section ranged 52-88 years	Cross Agency Reablement/ mainstream staff: Force field analysis focus group (11 staff); Survey Monkey online questionnaire (18); face to face interviews (13) Service users: 4 face to face interviews per service user over 6 months (n=13); telephone interviews (n=73); performance activity data (n=181)	For the performance activity data, clients had been supported through reablement during three time periods
<i>Glendinning et al. 2010[14],</i> England	2008-2010	Mixed methods	Over 90% in each group were aged over 65 years, with a mean age at baseline of 80 years in both groups	1,015 people recruited, 654 to reablement, 361 to comparison group 633 participants lost to study between recruitment and follow-up at 9 to 12 months	Conventional home care service use
<i>Jacobi et al. 2020[23],</i> England	2008-2012	Quantitative	Participants were aged 60-99 years	Dataset included 8,118 clients	T0 (start of the programme) and T1 (time of assessment, 13 weeks after discharge)
<i>King and Young 2022[33],</i> England	Not specified	Qualitative	Participants were using private domiciliary care	Two owners/managers of PDCAs	Not specified

			who provided care to adults aged over 18 years		
<i>Legg et al. 2016[34]</i>	2000-2015	Systematic review	The study authors planned to accept the definition of the population of interest used each study	N/A	No care or usual care in people referred to public funded personal care services
<i>Rabiee and Glendinning 2011[15],</i> England	2009	Qualitative	Adults aged over 18 years who were newly referred for home care services	Eight senior service managers Observation visits to the homes of 26 users Focus groups with 37 front-line staff	Service users who were at different stages in the course of a reablement episode
<i>Slater and Hasson 2018 [29],</i> Northern Ireland	2013-2014	Quantitative	The average age of participants was 76.5 years, with clients aged 26-99 years	A consecutive sample of 416 participants	Pre-intervention and post-intervention
<i>Whitehead et al. 2015 [35],</i> unspecified	Prior to 2014	Systematic review	Participants included individuals aged over 18 years, living at home in the community and using home care	4975 participants across 13 included studies. Sample size between 74 and 1382, mean of 383 (and 276 in RCTs, 474 in controlled before-after studies)	Routine home care where assistance with activities of daily living was provided, but no intention to improve individual performance
<i>Wilde and Glendinning 2012[16],</i> England	2010	Qualitative	Service users drawn from local authorities with well-established home care reablement services	34 service users and 10 carers	Not specified
Rehabilitation					
<i>Conroy et al. 2010 [21],</i> England	2005-2008	Quantitative	Older people aged over 70 years (mean age 79 years)	364 participants	Falls prevention information leaflet, with no further intervention offered

<i>Parker et al. 2011[30],</i> England	Not specified	Quantitative	Participants of any age (day hospital rehabilitation mean age 76 years; hospital-based rehabilitation mean age 74 years)	89 patients referred for multidisciplinary rehabilitation; 84 were randomised	Day hospital rehabilitation
<i>Sahota et al. 2016[18],</i> England	2013-2015	Quantitative	Frail older people aged over 70 years admitted to hospital as an acute medical emergency, although not bed bound or nursing home residents	250 participants randomised, 212 participants included in the primary analysis	Hospital-based rehabilitation
<i>Sahota et al. 2017[19],</i> England	2013-2014	Mixed methods	Patients aged over 70 years (mean age 84.1 years)	250 participants randomised: 125 to CIRACT and 125 to THB-Rehab 212 participants were followed up and included in the primary analysis Qualitative interviews :6 service leaders and key staff. Short ethnographic interviews with 200 staff Semi-structured interviews with 13 participants: 2 managers, 6 therapists, 2 discharge co-ordinators, 1 senior nurse, 1 social worker and 1 care home manager.	Traditional hospital-based rehabilitation

Abbreviations: CmH=community hospital; ICS=Intensive Community Service; HAH=Hospital at Home; CIRACT= Community In-reach Rehabilitation and Care Transition (CIRACT)