

Introduction

This discussion paper presents a review of literature available in the English-language on the subject of reablement and frail older people from the past 15 years, covering research conducted in Australia, Canada, northern and southern Europe, New Zealand, the United Kingdom and the United States of America. The paper provides an overview of the features of frailty and of the reablement model of community health and social care, and explores the key question of whether reablement can be a cost-effective way of promoting functional independence and optimising quality of life for frail older adults living at home.

Frailty: The Extent of the Problem

Population ageing is a feature of virtually all countries in the world. It is estimated, for example, that 22% of OECD nation populations will be aged 65 years and over by 2030. The percentage of older people (80 years and above) is also increasing significantly, and is predicted to triple in Europe between 2008 and 2060 (Cochrane, 2013). The World Health Organization (WHO) predicts that there will be 395 million people around the world aged 80 years and over by 2050 (WHO, 2015). People age very differently and many retain good health well into old age. However, others experience multiple, often chronic conditions and a degree of functional, sensory and cognitive impairment as they age. For example, American studies reveal that close to 50 percent of people over the age of 75 years have three or more chronic conditions (Goodwin, 2014; van Leeuwen, 2015).

No universally accepted definition of frailty exists, although a pilot study is currently seeking to overcome this lack of consensus by developing a Frailty Index (Jones, 2012). Frailty is generally considered to be a pre-disability biological syndrome that has a higher reversibility in its early stages than disability, and a higher predictive value for adverse outcomes at older age than chronic disease (Rodriguez-Mañas, 2014). It is characterised by a range of health factors which compromise the individual's good health and functionality such as impaired mobility, instability (risk of falling), cognitive decline, incontinence and adverse effects of medical treatment, any of which can result in disability, hospitalisation and death (Fried, 2001; Sinclair, 2005; van Leeuwen, 2015). The prevalence of frailty increases with age, and it is the most common cause of death in community-dwelling older people through the cumulative effect of a number of health deficits (Rodriguez-Mañas, 2014; Song, 2010).

Two standards for measuring frailty are commonly employed. One is the Cardiovascular Health Study (CHS) Frailty Phenotype, which diagnoses frailty in individuals who demonstrate three or more of five criteria: slow walking speed, weak grip strength, extreme fatigue, frequent infections, low energy, and unexplained weight loss. The other is the Cumulative Deficit Model which measures the sum of deficits in an individual, such as cognition, medically confirmed chronic disease, and psychological and social deficits. Other measures of frailty use a combination of instruments, each of which assesses a single aspect (Cameron 2013).

A state of frailty is a key indicator of the individual's health and needs, although researchers note the complexity of defining 'symptoms of frailty' and assessing the care needs of such a heterogeneous group (Andrew, 2012; Dubuc, 2013; Wallace, 2012). Frailty impacts upon an individual's quality of life in many, often co-existent ways. These include isolation and loneliness associated with chronic illness, low energy and reduced mobility, loss of loved ones and a reduced social network; persistent low mood, affected by the factors previously described; memory problems; and a sense of reduced control over their life resulting from increasing levels of dependency (van Leeuwen, 2015; Windle, 2011).

The decline in independent functional ability caused by frailty is even more of a problem for the increasing numbers of frail older people with complex care needs who live alone, especially when they have inadequate access to the 'informal care' usually provided by family members and close friends, as a result of labour market trends and changing family arrangements (Lewis, 2014; Lipszyc, 2012). Moreover, their state of frailty can be exacerbated by physical and environmental risk factors and stressors, causing susceptibility to infection, further disability and difficulty in re-establishing equilibrium after a disruptive event such as hospitalisation (Dubuc, 2013; Fairhall, 2013; van Leeuwen, 2015; Wallace, 2012). In consequence, a growing demand by the frail elderly on community health and social care services is evident. And since many older people wish to remain at home for as long as possible, with formal and informal support, reablement as a key platform of care is rapidly evolving to meet the need (Cochrane, 2013; Francis, 2011; Goodwin, 2014; Ryburn, 2009).

Reablement

Reablement (also known as 'restorative care' in Australia, New Zealand and the USA) can be described as a philosophy or a policy approach within community health and social care services. While it shares some features with traditional domiciliary care and occupational therapy, its focus is innovative. Commonly delivered as an intensive (multiple visits), duration-specific (typically between six and twelve weeks), multidisciplinary home care service, reablement focuses on user-identified goals and outcomes (Cochrane A, 2013). In encouraging and guiding older people to do things for themselves rather than have things done 'for' or 'to' them, reablement seeks to maximise independence and increase quality of life, delay hospitalisation and institutionalisation, and reduce mortality (Cochrane, 2013). Care plans are devised in consultation with the individual and their caregiver, consisting of a tailored set of user-agreed tasks and goals based on activities of daily living (ADL) and functional independence, through which the individual can (re)build confidence in their own capacity for control over their life (Glendinning, 2008). These care plans include a range of interventions such as physical exercise and mobility support, education about nutrition, lifestyle and self-management of chronic conditions, environmental redesign within the home, the provision of equipment aids, and strategies to manage anxiety and depression, with the longer-term goal of reducing the need for home care support into the future (Glendinning, 2010; Ryburn, 2009).

Public expenditure on long-term care poses a challenge to fiscal sustainability, and countries where the population has matured are already facing this challenge. The average costs of European Union public expenditure on long-term care are predicted to double from 1.8 % in 2010 to 3.6 % of GDP in 2060 (European Commission, 2013). Close to 40% of the Dutch health care budget in 2011 was spent on care of older adults, with hospitalisation and institutionalisation accounting for a large proportion (van Leeuwen, 2015). Nations such as Australia, Denmark, the Netherlands, Norway, the United Kingdom (UK) and the United States (USA) have responded to the budgetary load by adopting the reablement model, to varying degrees (Cochrane, 2013). Examples include mandatory reablement throughout Denmark (Rostgaard, forthcoming), and a UK Department of Health investment of an extra £300 million a year in reablement services between 2012 and 2015 (Glendinning, 2010; Wilde, 2012).

Frail older people may gain access to a reablement program through a number of pathways, one of which is upon discharge from hospital. Many hospital discharge services are selective, only referring those older people whom they assess as most likely to benefit from reablement. Another common route is direct referral from the community such as the GP or local authority. Services receiving a community referral tend to adopt a more flexible approach, often though not always screening out only the terminally ill or people with advanced dementia (Cochrane, 2013; Glendinning, 2008, 2010; Rabiee, 2011). While some countries have an individualised, flexible program derived from a personal needs assessment and consultative pre-program visits by multidisciplinary teams or a health practitioner, others opt for a provider-controlled, less customised program (Cochrane, 2013; Kümpers, 2010).

What Constitutes ‘Good Care’ and Does Reablement Deliver It?

It is difficult to accurately define ‘good care’, especially in relation to such a heterogeneous group as frail older people (Dubuc, 2013; Lewis, 2014). Studies that have focused on the views of service users and informal caregivers report that program flexibility, being consulted about the desired goals and activities, clear information, caregiver involvement, and the relationship between the service user and provider all contribute to perceptions of receiving good care (Glendinning, 2010). Of these, the quality of relationships is paramount. Service users and informal caregivers commonly state that professional health and social care staff provide company and reassurance. The correlation between empathy and reablement makes these relationships of value in their own right, not simply as a pathway to a better health outcome (Barrie, 2013).

Does reablement deliver good care? Researchers agree that the scope and methodological reliability of the current literature do not allow for a conclusive answer to this question. Substantial variation across trials, together with a paucity of randomised controlled trials with large sample sizes and a longitudinal perspective, prevent a clear picture of the impact of the reablement model on both quality of life and public expenditure. Moreover, many trials choose to exclude frail older people on the basis of their co-morbidities and challenges to recruitment (Fairhall, 2013). Thus, any discussion of necessity rests on statistically significant results and ‘high probability’ outcome indicators.

High rates of functional decline are evident in the frail older population, more so following a period of hospitalisation (Parsons, 2013), and this decline can unintentionally be reinforced by the traditional home care model of doing things ‘to’ and ‘for’ the individual. In contrast, the reablement focus on encouraging people to improve their function in ADL by completing tasks themselves can have a positive impact on physical, psychological and social well-being. Physical function and mobility are integral to achieving independence in activities of daily life (ADL), facilitating the maintenance of social connectivity, and reducing morbidity (such as injuries from falling, a leading cause of hospitalisation) and mortality (Fairhall, 2013; Heinrich, 2009). Studies measuring accomplishments in ADL and mobility through physical exercise training programs for frail older people found statistically significant improvements at 12 months post-intervention (Cameron, 2013; Ryburn, 2009). These improvements were reflected in significantly higher health-related quality of life outcomes in comparison with users of conventional home care programs, and modest improvements in social care-related quality of life (Glendinning, 2010; Miller, 2013; Wilde, 2012). Several research projects currently underway in this area of research will contribute to the evidence. These include two intervention protocols, one studying the effect of home-care reablement services on maintaining and improving older adults’ functional independence (Cochrane, 2013), and the other investigating the efficacy of mobility training (Fairhall, 2013). A Danish study is comparing outcomes of a rehabilitation model introduced in two municipalities in Denmark for people over 65 who have experienced a loss of functionality (Socialstyrelsen, 2015); and a Norwegian study protocol for a randomised controlled trial is investigating the effect of reablement on ADL, physical functioning, health-related quality of life, use of health care services and costs (Tuntland, 2014).

Home equipment aids, introduced to improve mobility, encourage improvements in ADL and reduce the likelihood of falls, complement both physical exercise and mobility interventions. In addition to structural equipment to aid ambulation within and outside the home, assistive technologies are being employed for care provision, fall detection and mobility enhancement. These include telephone healthcare services and computerised personal devices, and are associated with positive indicators (Boger, 2011; MacNamara, 2012). Evidence suggests that home equipment and aids bring benefits beyond the functional purpose for which they are designed. By enabling self-sufficiency, privacy and independence, they can improve the person’s quality of life through boosting their confidence and self-esteem (Ryburn, 2009).

Can Reablement Be Cost-effective?

Conclusive evidence of cost-effectiveness is inhibited by the paucity of robust research and the complexity of comparing traditional home care and reablement models in different settings, each with their own costing structure (Lewin, 2013b). One study of a 12-month reablement model in the United Kingdom reported a 60% decrease in use of social care services when compared with users of traditional home care, noting however that this reduction in cost was offset by the initial costs of implementing the service. This study found no statistically significant variation in the costs of the combination of health and social care services used by both the reablement and traditional home care groups for the duration of the study, and no positive indicators for reduced use of health care services in the reablement group. Nonetheless, it concluded that reablement has a high probability of cost-effectiveness when considering longer-term effects (Glendinning, 2010).

A longitudinal study in Australia found a similar reduction in the use of home care services after the reablement program had concluded. While the reablement and traditional home care programs in the study incurred similar costs in the initial twelve-month period, reablement service users demonstrated a comparative reduction in need of any home care service over the next three years, and their need for personal care services remained low for longer, delivering a median cost saving of approximately AUD12,500 per person per year for nearly five years. Comparing these results with several other studies, the researchers concluded that the reablement models practised in the United Kingdom, New Zealand, Australia and the United States all showed a reduction in the subsequent use of social care services, but that no firm evidence is yet available for how long this may last in each setting (Lewin, 2013b).

Limitations and omissions in the research need to be considered. For example, a common focus on assessing reablement as a means to maximise the health care dollar through efficient use of resources can be at the expense of measuring outcomes related to quality of life. While a reduction in service resources is important to ensure public health funding sustainability over the long-term, it is also essential to evaluate indicators of quality of life benefits from reablement programs. Some studies exclusively measure reductions in paid staff hours after the reablement intervention as signs of success (Francis, 2011; Miller R, 2013; van Leeuwen, 2015) and fail to take into account staff 'time to care'. The time taken to build the relationship between care provider and user can be critical to the outcome, and it has been said that "practitioners *are* the intervention" in human services (Lewis, 2014).

There is as yet no reliable evidence to show that reablement has a material impact on frail older people's need for health support or hospitalisation—although there is a probability that improvements in mobility and physical functioning may delay or avoid hospitalisation through a reduced incidence of falls and other injuries. Improved well-being through positive social connectivity and care outcomes is only modestly supported by current research, and urgently needs investigation (Francis, 2011). A two-year randomised clinical trial assessing a chronic care model for frail older adults in Europe currently in progress will contribute to the evidence base of both quality of life gains and potential cost-effectiveness of the model (van Leeuwen, 2015).

Challenges and Omissions

In seeking to establish a cost-saving rationale for reablement, local authorities may overlook the variation in the cost of different reablement delivery models and the cost of the services they are replacing (Lewin, 2010). Some local authorities reduce their budget for community-dwelling older people's health and social care with the expectation of future cost-savings from successful reablement interventions, which they believe will result in less demand for home care over the long-term (Rostgaard, 2015). In Denmark, where reablement is now obligatory, there has been a reduction in the take-up of home care since 2007 when reablement was introduced. The cause of this reduction is unclear: it may be a result of the successful move towards the more active principles of reablement; or it may indicate that some older people are not having their care needs met because their resistance to engaging in the process of change that is central to the self-

care reablement model excludes them from receiving what is seen as more 'passive' or conventional home care services (Rostgaard, forthcoming).

Independently-minded older adults have a strong motivation to regain a level of functional independence that is acceptable to them, particularly following a disabling injury or illness which may have caused them to be hospitalised for a period of time (Francis, 2011; Langeland, 2014; Newton, 2014; Rostgaard, forthcoming). However, the increasingly widespread adoption of the all-inclusive reablement model by local authorities commonly fails to distinguish between those who are most likely to benefit from reablement and those who are disinclined to participate in the model (Newton, 2014). The latter group experiences a number of frustrations. They express reluctance to do difficult and painful tasks for themselves when they perceive it would be much easier and quicker for the formal caregiver to do them; and they state that they have unmet needs with housework, shopping, and their social activity goals (Glendinning, 2010). Difficulties are compounded where the user's and informal caregiver's understanding of the aims of reablement is poor or where the service delivery lacks flexibility (Glendinning, 2010; Wilde, 2012).

While many service users are highly satisfied, a key finding by researchers exploring the user and informal caregiver perspective is the experience of loneliness and an associated sense of loss and uncertainty as the reablement period ends (Fisher, 2011; Lewin, 2013a; Newton, 2014). The short-term nature of most reablement programs can create increased isolation and loneliness post-intervention, particularly for those who live alone with little or no family support. Loneliness is connected with depression and reduced well-being, and has been linked to poor sleep patterns, depressed immune system, elevated blood pressure and longer-term cognitive decline (Francis, 2011; Newton, 2014; O'Luanaigh, 2008; Wilde, 2012). Depression in older people is often under-diagnosed and its risk increases with age. There is a clear link between depression and suicide, and older adults are disproportionately likely to die by suicide. It is therefore imperative to promote positive ageing (Astell, 2013).

In practical terms, service users may complain of an inability to achieve their goals as a result of the lack of equipment and environmental adaptations, including bathroom aids and mobility support outside of the home (Wilde, 2012). This can be due to insufficient resources in the community or to delays in provision through poor communication within the interdisciplinary team (New, 2008). Because reablement programs are usually short-term, the prompt delivery of required home equipment aids is important. Service users and caregivers report satisfaction when equipment is delivered promptly and removed when no longer required, and experience high levels of frustration when there are delays (Francis, 2011). Gaining access to mobility and functional aids is associated with the role of the professional occupational therapist in the conventional care model. Some studies suggest that occupational therapists are essential members of reablement teams, while others assert that reablement home care staff can be trained to fulfil the same tasks, as long as service users have access to an occupational therapist and a physiotherapist if needed. The cost-effectiveness of an occupational therapist as a core member of the reablement team is inconclusive at present (Francis, 2011; Glendinning, 2010; Rabiee, 2011; SCIE, 2011).

Several challenges exist in relation to the training of staff in the reablement approach, although many managers and front-line staff have responded positively to the new model (Francis, 2011; Miller, 2013). Staff recruited from traditional home care services can be challenged by the paradigm shift from doing things 'to' or 'for' the person to motivating and encouraging them to become as independent as possible (Glendinning, 2008, 2010; Wilde, 2012). In communities where the reablement model co-exists with the mainstream home care service evidence shows a confusion between the two sets of skills, which can lead to decreased staff and user morale (Miller, 2013). Other challenges to user satisfaction, staff morale and program efficacy are:

- a time-pressured program delivery environment;
- developing an integrated multi-disciplinary team that supports the principles, goals and methods of reablement and maintains good communication channels;
- ensuring the availability of services and equipment within a short program time-frame;

- the education of providers of ongoing care after the intervention has concluded, in order to ensure longer-term viability of the gains achieved through the program; and
- sufficient health authority funding to ensure optimal conditions for program implementation (Cochrane, 2013; Francis, 2011; Miller, 2013; Rabiee, 2011; Ryburn, 2009).

Service users and caregivers need to receive clear information about how reablement differs from conventional care models if they are to engage fully with the program and avoid building unrealistic expectations. However, caregivers are often overlooked in reablement education, and their involvement may not be sought in setting goals and desired activity targets with the service user (Wilde, 2012). Evidence suggests that when informal caregivers are consulted and informed about reablement interventions, they may experience a reduced sense of burden and improved well-being and commitment to the program (Janse, 2014). An associated problem is the experience many frail older people have of lacking autonomy in devising their own care plan (van Leeuwen, 2015). Such direct feedback from users and their caregivers can inform decisions about the content and delivery of the program and how both may be modified for greater efficacy, yet robust research into user and caregiver views of reablement is currently not available (Glendinning, 2008; Janse, 2014; Wilde, 2012).

The potential for bias in program design and in service user eligibility is another challenge. Models which favour those who are seen as being 'temporarily disabled' with health conditions from which they can recover over those with progressive, chronic illness or long-term irreversible impairment can deliver care practices which work for the former but don't work well for the latter (Wilde, 2012). The emphasis on evaluating success by cost-savings in reduced hours of paid intervention, as noted above, could influence decisions about eligibility for the service, whereby only those considered likely to be successful according to this measure would be offered entry to the program (Miller, 2013). In both cases, service providers can favour a focus on physical functionality over emotional and social well-being (Rostgaard, forthcoming). Conversely, some reablement services swing too far in the opposite direction by adopting a 'one size fits all' approach to their intake referral system, in the process diluting the reablement principle of person-centred care through a flexible, tailored service that protects the user's choice and autonomy (Cochrane, 2013; Glendinning, 2010; Miller, 2013; Newton, 2014; Rabiee, 2011).

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REFERENCES

- Astell A (2013). Technology and Fun for a Happy Old Age. In Sixsmith A and Gutman G [eds], *Technologies for Active Aging: International perspectives on aging* 9(10): 169-187. Springer: New York, USA.
- Andrew MK, Fisk JD and Rockwood K (2012). Psychological Well-being in Relation to Frailty: A frailty identity crisis? *International Psychogeriatrics* 24(08):1347-1353. Canada.
- Barrie K (2013). 'We've Got to Talk about Outcomes'. Rethinking Enablement: The enabling potential of outcomes focused working. Alliance Report 4. Health and Social Care Alliance Scotland.
- Boger J and Mihailidis A (2011). The Future of Intelligent Assistive Technologies for Cognition: Devices under development to support independent living and aging-with-choice. *NeuroRehabilitation* 28(3):271-280.
- Cameron ID, Fairhall N, Langron C et al (2013). A Multifactorial Interdisciplinary Intervention Reduces Frailty in Older People: Randomized trial. *BMC Medicine* 11(65). Denmark.
- Cochrane A, McGilloway S, Furlong M et al (2013). Home-care 'Re-Ablement' Services for Maintaining and Improving Older Adults' Functional Independence (Protocol). *Cochrane Database of Systematic Reviews* 11.
- Commonwealth of Australia (2012). Living Longer. Living Better.
- Cruise CM, Sasson N and Lee MHM (2006). Rehabilitation Outcomes in the Older Adult. *Clinics in Geriatric Medicine* 22(2): 257-267. USA.
- Department of Health UK (2007). Homecare Re-ablement. Efficiency Delivery: Supporting sustainable transformation. Discussion Document.
- Department of Health UK (2007). Homecare Re-ablement. Retrospective Longitudinal Study.
- Department of Health UK (nd). Homecare Re-ablement. Benefits of Homecare Re-ablement for People at Different Levels of Need.
- Dubuc N, Bonin L, Tourigny A et al (2013). Development of Integrated Care Pathways: Toward a care management system to meet the needs of frail and disabled community-dwelling older people. *International Journal of Integrated Care* 13: e017. Canada.
- Eklund F, Treschow A and Ringström A (2014). Increase Independence and Reduce the Need for Elderly Care in a Scandinavian Setting? *The European Journal of Public Health* 24(suppl 2): cku151-012. Sweden.
- European Commission (2013). Long-term Care in Ageing Societies: Challenges and policy options. Commission Staff Working Document SWD 41/2. Belgium.
- Fairhall NJ, Sherrington C and Cameron ID (2013). Mobility Training for Increasing Mobility and Functioning in Older People with Frailty (Protocol). *Cochrane Database of Systematic Reviews* 5.
- Fleming S, Blake H, Gladman JRF et al (2004). A Randomised Controlled Trial of a Care Home Rehabilitation Service to Reduce Long-Term Institutionalisation for Elderly People. *Age and Ageing* 33(4): 384-390. UK.
- Forster A, Lambley R and Young JB (2010). Is Physical Rehabilitation for Older People in Long-Term Care Effective? Findings from a systematic review. *Age and Ageing* 39(2): 169-175.
- Francis J, Fisher M and Rutter D (2011). Reablement: A cost effective route to better outcomes. *SCIE Research Briefing* 36. UK.
- Fried LP, Tangen CM, Walston J et al (2001). Frailty in Older Adults: Evidence for a phenotype. *Journal of Gerontology* 56A(3): M146-M156.
- Gerald Pilkington Associates (2011). The Cost Effectiveness of Homecare Re-Ablement: A discussion paper to explore the conclusions that can be drawn from the body of evidence. UK.
- Gerald Pilkington Associates (2011). The Outsourcing of Homecare Re-Ablement Services: A discussion paper to outline the trends, options and recommended approach to outsourcing homecare re-ablement services. UK.
- Glendinning C, Jones K, Baxter K et al (2010). Home Care Re-Ablement Services: Investigating the longer-term impacts (prospective longitudinal study). University of York. UK.

Glendinning C and Newbronner E (2008). The Effectiveness of Home Care Reablement—Developing the Evidence Base. *Journal of Integrated Care* 16(4): 32-39. UK.

Goodwin N, Dixon A, Anderson G and Wodchis W (2014). Providing Integrated Care for Older People with Complex Needs. Lessons from seven international case studies. *London: The King's Fund*. UK.

Gray LC, Travers CM, Bartlett HP et al (2008). Transition Care: Will it deliver? *Medical Journal of Australia* 188(4): 251-253. Australia.

Heinrich S, Rapp SK, Rissmann U et al (2009). Cost of Falls in Old Age: A systematic review. *Osteoporosis International* 21(6): 891-902.

Janse B, Huijsman R, de Kuyper RDM and Fabbriotti IN (2014). The Effects of an Integrated Care Intervention for The Frail Elderly on Informal Caregivers: A quasi-experimental study. *BMC Geriatrics* 14:58. The Netherlands.

Jones G, Wallace C, Kenkre J et al (2012). Pilot Study Protocol: Developing a frailty index. *GSTF International Journal of BioSciences* 2(1): 98-103. UK.

Jones KC, Baxter K and Curtis LA (2009). Investigating the Longer Term Impact of Home Care Re-ablement Services: The short-term outcomes and costs of home care re-ablement services interim report. Working Paper Number DHR 2378. Universities of Kent and York. UK.

Kümpers S, Allen K and Campbell L (2010). Prevention and Rehabilitation within Long-term Care across Europe: European overview paper. Berlin/Copenhagen/Vienna: Interlinks.

Langeland E (2014). Rehabilitation of Everyday Function in Community-Dwelling Adults (hverdagsrehabilitering). An intervention study. Bergen University College. Norway.

Lewin G, De San Miguel K, Knuiman M et al (2013a). A Randomised Controlled Trial of the Home Independence Program, an Australian Restorative Home-Care Programme for Older Adults. *Health and Social Care in the Community* 21(1): 69-78.

Lewin GF, Alfonso HS and Alan JJ (2013b). Evidence for the Long Term Cost Effectiveness of Home Care Reablement Programs. *Clinical Interventions in Aging* 8: 1273-1281. Australia.

Lewin G and Vandermeulen S (2010). A Non-Randomised Controlled Trial of the Home Independence Program (HIP): An Australian restorative programme for older home-care clients. *Health and Social Care in the Community* 18(1): 91–99.

Lewis J and West A (2014). Re-Shaping Social Care Services for Older People in England: Policy development and the problem of achieving 'good care'. *Journal of Social Policy* 43(1): 1-18.

MacNamara GF (2012). Reshaping Care for Frail Older People in Scotland: An outcomes-focused evaluation of telehealthcare services in Falkirk. PhD thesis.

Manthorpe J (2011). Long-term Impact of Home Care Reablement. *Community Care* 32-33. UK.

McLeod B and Mair M (2009). Evaluation of City of Edinburgh Council Home Care Re-Ablement Service. Social Research for Health and Community Care, Scotland.

Miller R and Allen K (2013). Prevention Services, Social Care and Older People: Much discussed but little researched? NIHR School for Social Care Research, UK.

Miller E (2014). Embedding Outcomes in Reablement in North Lanarkshire: Summary report. University of Strathclyde, Scotland.

Miller E (2013). Embedding Outcomes in the Reablement Model in North Lanarkshire. University of Strathclyde, Scotland.

Miller E, Whoriskey M and Cook A (2008). Outcomes for Users and Carers in the Context of Health and Social Care Partnership Working: From research to practice. *Journal of Integrated Care* 16(2): 21-28. Scotland.

Morse A (2014). Adult Social Care in England: Overview. Report by the Comptroller and Auditor General. Department of Health, Department for Communities and Local Government. UK.

- Muntinga ME, Hoogendijk EO, van Leeuwen KM et al (2012). Implementing the Chronic Care Model for Frail Older Adults in The Netherlands: Study protocol of ACT (frail older adults: care in transition). *BMC Geriatrics* 12:19. The Netherlands.
- New PW and Poulos CJ (2008). Functional Improvement of the Australian Health Care System—Can Rehabilitation Assist? *Medical Journal of Australia* 189(6): 340-343.
- Newbronner E, Baxter M and Chamberlain R (2007). Research into the Longer Term Effects / Impacts of Re-ablement Services. Department of Health/ Care Services Efficiency Delivery (CSED) Programme. UK.
- Newton C (2014). Personalising Reablement: Inserting the missing link. Report Information from ProQuest. Aalborg University Library. Denmark.
- O'Lunaigh C and Lawlor BA (2008). Loneliness and the Health of Older People. *International Journal of Geriatric Psychiatry* 23(12): 1213–1221.
- Parsons JGM, Sheridan N, Rouse P et al (2013). A Randomized Controlled Trial to Determine the Effect of a Model of Restorative Home Care on Physical Function and Social Support among Older People. *Archives of Physical Medicine and Rehabilitation* 94(6): 1015–1022. New Zealand.
- Petch A, Cook A and Miller E (2013). Partnership Working and Outcomes: Do health and social care partnerships deliver for users and carers? *Health and Social Care in the Community* 21(6): 623-633. UK.
- Rabiee P and Glendinning C (2011). Organisation and Delivery of Home Care Re-Ablement: What makes a difference? *Health and Social Care in the Community* 19(5): 495-503. UK.
- Research in Practice for Adults (nd). Reablement: Policy, research and practice briefing. Dartington. UK.
- Rodriguez-Mañas L and Fried LP (2014). Frailty in the Clinical Scenario. *The Lancet* 385: e7-e9.
- Rostgaard T (forthcoming). Failing Ageing? Risk management in the active ageing society. In Larsen JE, Frederiksen M and Bengtsson T [eds], *Risk and the Modern Welfare State—Sociological Investigations of the Danish Case*. Palgrave MacMillan.
- Rostgaard T (2015). Kvalitetsreformer i hjemmeplejen – den svære balance mellem standardisering og individualisering. In Jensen PH and Rostgaard T [eds], *Det aldrende samfund – udfordring eller nye muligheder*. Frydenlund Academics: Copenhagen.
- Ruppe G (2011). Active Ageing and Prevention in the Context of Long-Term Care: Rethinking concepts and practices. European Centre for Social Welfare Policy and Research. Policy Brief, July 2011. Austria.
- Ryburn B, Wells Y and Foreman P (2009). Enabling Independence: Restorative approaches to home care provision for frail older adults. *Health and Social Care in the Community* 17(3): 225-234.
- SCIE (2013). Maximising the Potential of Reablement. Guide 49. UK.
- SCIE (2012). Reablement: Key issues for commissioners of adult social care. At A Glance 52. UK.
- SCIE (2011). Reablement: Emerging practice messages. UK.
- SCIE (2011). Reablement: A key role for occupational therapists. At A Glance 46. UK.
- Sinclair AJ (2005). Diabetes Mellitus in Senior Citizens – A major threat to personal independence (Editorial). *The British Journal of Diabetes & Vascular Disease* 5:3-5. UK.
- Sloan JP (2014). Joining Up Care Around The Individual—Lessons from Vancouver. *Journal of Integrated Care* 22(2): 32-38. Canada.
- Socialstyrelsen Viden Til Gavn (2015). SFI (The Danish National Research Institute) <http://socialstyrelsen.dk/projekter-og-initiativer/aeldre/rehabilitering-pa-aelderromradet>. Accessed 23 July 2015.
- Song X, Mitnitski A and Rockwood K (2010). Prevalence and 10-Year Outcomes of Frailty in Older Adults in Relation to Deficit Accumulation. *Journal of the American Geriatrics Society* 58(4): 681-687. Canada.
- Tinetti ME, Baker D, Gallo WT et al (2002). Evaluation of Restorative Care vs Usual Care for Older Adults Receiving an Acute Episode of Home Care. *The Journal of the American Medical Association [JAMA]* 287(16): 2098-2105. USA.

Tuntland H, Espehaug B, Forland O et al (2014). Reablement in Community-Dwelling Adults: Study protocol for a randomised controlled trial. *BMC Geriatrics* 14:139. Norway.

Vähäkangas P, Noro A and Björkgren M (2006). Provision of Rehabilitation Nursing in Long-term Care Facilities. *Journal of Advanced Nursing* 55(1): 29-35. Finland.

van Leeuwen KM (2015). Integrated Care and Quality of Life of Frail Older Adults: How can we measure what we aim to improve? PhD thesis. Denmark.

van Leeuwen KM, Malley J, Bosmans JE et al (2014). What Can Local Authorities Do To Improve the Social Care-Related Quality of Life of Older Adults Living at Home? Evidence from the Adult Social Care Survey. *Health & Place* 29: 104-113. Denmark.

WA Department of Health & Victorian Department of Health (2010). Background Paper on Wellness and Reablement Approaches to Delivering Home and Community Care Services in WA and Victoria. Australia.

Wallace C, Chandler L, Rogers A et al (2012). Caring for Frail Patients: Best practice. *Nursing Standard* 26(28): 50-56. UK.

Wilde A and Glendinning C (2012). 'If They're Helping Me Then How Can I Be Independent?' The perceptions and experience of users of home-care re-ablement services. *Health and Social Care in the Community* 20(6): 583-590. UK.

Windle K, Francis J and Coomber C (2011). Preventing Loneliness and Social Isolation: Interventions and outcomes. Social Care Institute for Excellence (SCIE) Research briefing 39. UK.

Wood C and Salter J (2012). Housing Providers Can Play a Vital Role in Rehabilitation and Reablement... The Home Cure. Demos. UK.

World Health Organization (2015). Are You Ready? What you need to know about ageing. www.who.int/world-health-day/2012/toolkit/background/en/. Accessed 16 May 2015.