FULL REPORT
This report gives an account of a one year knowledge exchange project, jointly funded by the ESRC and North Lanarkshire Council, conducted in partnership with the University of Strathclyde, and supported by IRISS. The purpose of the project was to bring together two key recent service developments, by further embedding personal outcomes into home care reablement.

Embedding outcomes in the reablement model in North Lanarkshire

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Introduction

There is currently much concern about managing dwindling resources against increasing demand for services in the UK and beyond. Associated with this is the policy emphasis on shifting the balance of care, so that more people are supported to stay well, closer to home (Scottish Government 2007). Delivering on this agenda requires building on and further developing person-centred and enabling practice. Yet, despite continued efforts to support both the independence and quality of life of people using services, these goals can be elusive (Miller, 2011).

It has been argued that if staff and organisations are to deliver on this challenging transformational agenda, innovation should be cognizant of relevant evidence and be supported by effective knowledge exchange (Cooksey, 2006). In achieving effective exchange between research and practice, three factors have been highlighted as important. These are the need to understand the context of implementation, to establish the credibility of the findings and the adoption of interactive and facilitative approaches (Nutley et al, 2007). Barriers to research implementation need to be investigated and addressed and the practice implications of innovations need to be understood, acknowledged and communicated in exchanges with practitioners.

This project was set up between Glasgow School of Social Work and a partner local authority, North Lanarkshire Council, to investigate the potential for and means of implementing evidence (drawing upon formal research studies, practitioner wisdom and user and carer perspectives) about outcomes based working in the context of home care re-ablement in North Lanarkshire. The project was set up in association with IRISS (Institute for Research and Innovation into Social Services). The focus of the project involved various stakeholders within North Lanarkshire Council and close work with two reablement teams. These two service developments, reablement and personal outcomes based working, will be discussed in the body of the report, with brief definitions considered here.

There is current emphasis on re-ablement as a service solution to address demographic concerns. Homecare re-ablement can be defined as an input that aims to maximise [service] users long term independence, choice and quality of life, to appropriately minimise on-going support required and to consequently minimise the whole-life cost of care (CSED, 2007). This is mainly achieved by moving from a more traditional model of home care which is largely commissioned on the basis of brief time slots, with a focus on predefined tasks completed *for* rather than *with* service users (Ryburn et al, 2008). Reablement places more emphasis on supporting individuals to carry out key tasks for themselves, in order to achieve maximum independence.

The second service innovation relevant to this project is outcomes based working. Outcomes have become a significant policy theme in health and social care in the UK. The Social Policy Research Unit (SPRU) at York University (Nicholas et al, 2003) defined outcomes as the impact of support and/or services on individuals, and crucially, that the person should be involved in defining the outcome(s) important to them. Outcomes-focused services are further described as "those that meet the goals, aspirations or priorities of individual service users. They can be contrasted with services whose goals, content or mode of delivery are standardised, regardless of the

circumstances of those who use them; or are determined primarily by commissioners or providers rather than users" (Glendinning et al, 2008).

The outcomes model informing this proposal is Talking Points, which emerged through two phases. The first phase involved a Department of Health project involving two co-applicants (Petch et al, 2007). The second phase has involved long-term knowledge exchange between the researcher and practice settings, sponsored by the Joint Improvement Team of the Scottish government (Cook and Miller 2012). Talking Points aims to re-orientate the focus of services, around the outcomes important to the person. This requires consideration not just of 'what' is done, but also 'why,' thereby tapping into individual motivation. Additionally, the approach includes consideration of quality of life as well as change outcomes, identified by project partners as a necessary development for reablement. In addition to increased service user and carer involvement, benefits include greater clarity of purpose and a focus on maximizing independence. The information gathered from these interactions can be collated to apply to service improvements, performance management and commissioning (Cook and Miller 2012).

As will be identified in the literature review and subsequent sections of this report, it is possible to identify a range of reasons for embedding outcomes in reablement. However, a key motivating factor for the project partners was accumulating evidence that although time-limited re-ablement services, when successful, can improve change outcomes for individuals in the short term, there was also a need to consider that fact that many older people are as equally concerned about *maintenance* or quality of life outcomes as they are about *change* outcomes (Andrews et al, 2009).

Background

North Lanarkshire is the fourth largest local authority in Scotland. In line with wider UK trends, its population is projected to shift significantly over the next thirty years towards retirement age. Previously a heavy industrial area, North Lanarkshire enjoyed economic recovery, particularly in the service sector, in the first decade of this century. However, Lanarkshire continues to have the second largest national share of the most deprived areas in Scotland, behind only Glasgow, with lower than average life and healthy life expectancy (North Lanarkshire Partnership, 2009).

North Lanarkshire was a very early implementer of outcomes-based working in Scotland. Outcomes focused assessment and planning has been in development since 2008 and a number of significant associated changes have been made to services and support. Some key developments are as follows:

• re-organisation of integrated day provision for older people from 2009
• multidisciplinary locality planning groups for older people
• Locality Link Officers since 2009, who ensure that individuals requiring lower levels of support are supported to be involved in their community
• re-orientation of home care towards re-ablement in all six localities following the Best Value Review of home care in August 2009
• Partnership 4 Change, a local user and carer forum is actively involved in shaping developments; and informed 'Living Well in North Lanarkshire,' the quality of life strategy for older people

- Significant investment in community capacity building, funded by the Scottish Government Change Fund, and intended to improve informal supports and services to support the independence and quality of life of older people

While there has been significant progress with implementing outcomes focused practice since 2008, North Lanarkshire acknowledges that there is a long journey involved, and continuing development is required. Further to this, there is a recognized need to embed outcomes focused practice in the recently established reablement service. There is also an intention to introduce a systematic approach to gathering user and carer feedback, which could be improved by outcomes focused planning and reviews. Early evidence from within North Lanarkshire suggested that there has been progress with regard to change outcomes in reablement, but quality of life also needs to be considered (Mackay, 2010).

Aims, objectives and project questions

Given this background the project set out with the aim of investigating the potential for, and means of implementing evidence about outcomes in reablement in North Lanarkshire. To achieve this aim the following objectives were established.

- To build on existing knowledge exchange activity between the researcher and the partner (North Lanarkshire Council) by investigating in detail an issue which is both a local priority and a national policy imperative.
- To establish current practice with regard to outcomes within homecare reablement services in North Lanarkshire.
- To explore the applicability of existing evidence about outcomes in a practice setting using a knowledge exchange process, which will distill key messages from formal research studies, practice wisdom and user/carer perspectives.
- To establish the challenges in the existing approach to outcomes within homecare re-ablement, using a case study approach within two homecare re-ablement services in North Lanarkshire.
- To capture new insights gained from the project and generate guidance and tools to support continuing implementation both locally and nationally, including audio-visual material on embedding outcomes in homecare and re-ablement.

Through discussions between the project partners during the application phase, the following questions were generated to inform the direction of the project.

Project questions and activity

- To what extent is outcomes based working currently understood and enacted by staff involved in care at home services?
- What additional support is required to ensure outcomes based working is understood and that outcomes are effectively recorded by staff?
- To what extent are quality of life outcomes being considered alongside change outcomes by staff involved in re-ablement services?

- What additional support is required to ensure that quality of life outcomes are considered, addressed and recorded by staff?
- To what extent can outcomes based working inform and be informed by the development and implementation of the new performance management framework?
- To what extent can the work on embedding outcomes in care at home inform and be informed by related developments in North Lanarkshire on improved recording of outcomes and outcomes based leadership?
- How can outcomes data be used to greatest effect to inform a range of other requirements including service planning, commissioning and related developments?

Change project model

The project proposed that these questions could be addressed by the intensive model of engagement set out in a modified version of the Change Project methodology developed with social services practitioners by Research in Practice (RiP) and Research in Practice for Adults (RiPfA), the key knowledge exchange organisations in this field in England. Effective knowledge exchange was therefore to be supported by existing relationships and knowledge exchange activity between the partners and enhanced by use of the RiPFA model. The stages as planned are set out below, and any changes from the planned model are noted in brackets following each stage:

Stage 1 will establish key messages from the literature as they relate to outcomes and re-ablement. In addition a small number of strategic staff within the local authority and other providers will be interviewed to establish a baseline for current practice.
Stage 2 will test out via focus groups the applicability of the key messages identified in stage 1 with practitioners and managers across two re-ablement teams in North Lanarkshire.
Stage 3 will synthesise the messages from research via an Expert Group comprising practitioners, researchers and external advisors including Partnership4Change. Volunteers will also be recruited for digital stories.
Stage 4 will produce detailed guidance on the optimum model of practice, including relevant tools to ensure outcomes are embedded in the re-ablement model in North Lanarkshire
Stage 5 will test guidance and tools through a second focus group to consider any challenges and concerns from the practitioners.
Stage 6 will convene a second Expert Group meeting to finalise the model to be developed. A further output of this event will be detailed guidance for dissemination.
Stage 7 will involve implementation of the model within North Lanarkshire.
Stage 8 will focus on dissemination of project outputs across Scotland and beyond via IRISS.

Reflecting the reality of working in rapidly evolving service contexts, a key objective was to change early in the project, with significant implications for the change model. These changes will be documented in chapter five, before being discussed in the concluding section. The next four chapters relate to the early stages of the change model, documenting the findings of the literature review, interviews, focus groups and residential retreat.

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Chapter One: Literature review

This literature review was undertaken by conducting searches of key relevant journals and databases, using the terms reablement and restorative homecare, which was discovered at the outset to be the term used in the US, Australia and New Zealand. The journals searched were *Health and Social Care in the Community* and the *Journal of Integrated Care* and the websites were PubMed, Google Scholar and Care Knowledge. Strict inclusion and exclusion criteria were not applied because the literature on this topic is still limited. The literature includes empirical studies, literature reviews, a policy document and practice guides. Most of the literature is from England, with a limited number of references from Scotland, Wales, New Zealand, Australia and the US.

While cost-effectiveness is a theme in the literature, it is not a priority of this project and there is no attempt to evalute the validity of relevant studies. Given the knowledge exchange focus of this project, attention was paid to the perspectives of various stakeholders in the process, and potential implications of these perspectives for embedding outcomes in reablement. The final section of this review therefore highlights messages on the potential benefits of embedding personal outcomes in reablement. More general conclusions on the overall evidence and their relation to the findings of this project will be discussed in the concluding section.

Definition

Homecare re-ablement has been defined as an input that aims to:

> Maximise [service] users long-term independence, choice and quality of life, to appropriately minimise on-going support required and to consequently minimise the whole-life cost of care (CSED, 2007)

The aim therefore is to increase service users confidence and skills with the eventual goal being a reduction or withdrawal of services (McIntyre and Stewart 2010). Distinctive components are said to be the focus on assisting people to regain abilities (SCIE 2011) and the role of active re-assessment to ensure that ongoing support is tailored to the fluctuating needs of people's recovery (Rabiee and Glendinning 2011, SCIE 2011, SCIE 2013).

A recent Australian review of the evidence defined reablement more broadly as including connections to the community as follows:

> Reablement is a planned approach to community care and services for older people that aims to help them re-establish daily living skills and community connections through a time limited, goal-oriented program (Benevolent Society 2011).

The term restorative care is more commonly used in the US, New Zealand and Australia (King et al 2012b, SCIE 2011a), although reablement is also used in Australia (Benevolent Society 2011).

Organisation and delivery

Homecare reablement in the UK has largely developed from traditional local authority in-house home care services (McLeod and Mair 2009, Rabiee and Glendinning 2011). Reablement can be provided for anything from a few days up to many weeks, depending on the individual's capacity and needs, with six weeks being the average (Rabiee and Glendinning 2010). The service is usually provided free for the first six weeks. Towards the end of the reablement period, decisions will be made on addressing future needs, either through withdrawal of services, further homecare or the provision of other services (IRISS, 2010).

Reablement can be distinguished from traditional home care in various respects. This includes the emphasis on doing thing *with* rather than *to* people, as supported by flexibility and duration of visits, as compared to mainstream care, which is usually commissioned on the basis of delivery of specified tasks within a limited and fixed time. The flexibility over length of visits has been identified as crucial, particularly at the start of a reablement episode (Rabiee and Glendinning 2010).

Reablement teams tend to incorporate home care staff and a manager, as well as including Occupational Therapists, either as core team members or on a collaborative basis (SCIE 2011b). Reablement support staff are largely recruited from existing home care staff with some additional recruitment (Rabiee and Glendinning 2011). An Australian study identified involvement of OTs, physiotherapists and nurses (Lewin and Vandermeulen 2010). The way reablement has developed has sought to overcome some of the challenges identified internationally in relation to traditional home care, including recruitment and retention, high turnover rates, inadequate training and supervision and reduced continuity of care (King et al 2012b), as discussed in the section on staff.

The importance of the articulation of a clear vision for the services has been highlighted, as well as the need to share this understanding beyond reablement teams to care managers and NHS staff too, to ensure appropriate referrals and discharges (Rabiee and Glendinning 2011).

Who can be included in reablement

Re-ablement has largely developed in response to concerns about demographic pressures, and the majority of users are older people. However it includes services for people with poor physical and/or mental health; to help them accommodate their illness by learning or re-learning the skills for daily living. Some localities offer staff additional training on dementia, visual impairments or mental health problems (Rabiee and Glendinning 2010). Although varying views have been reported on the inclusion of people with dementia, recent studies support this (SCIE 2011). One study found that for people with dementia or mental health problems, it was beneficial to limit involvement with each individual to two or three workers with specialist training (Rabiee and Glendinning 2010). In New Zealand, Parsons and Parsons (2012) found that alternative strategies were required for goal setting for people with significant cognitive impairment, following trial of their designated tool. Research evidence in this area remains limited (SCIE 2013) but recent recommendations are that people should be assessed on the basis of their strengths without prejudice about potential to

be included and that the objective may be more flexible about preserving and encouraging a more functional state than about independence (SCIE 2013).

Policy

There is a recent marked shift in ageing policy in many developed countries, from emphasising old age as a dependent life stage to re-conceptualisations of active ageing and self-management (Lewin et al 2012). In England, the Care Services Efficiency Delivery (CSED) programme was established in 2004 by the Department of Health to aid councils to develop and deliver more efficient adult social care including reablement. In Scotland, the overarching policy framework is Reshaping Care for Older People. The main goal of this programme is 'to optimise the independence of people at home or in a homely setting' (SG 2011). Again, reablement is viewed as an important aspect of this programme, with the earliest work in Scotland beginning in Edinburgh (McLeod and Mair 2009).

Assisting older people to continue living independently at home and avoid premature institutionalization has been the goal of the Australian Home and Community Care programme since its inception in 1985 (Lewin and Vandermeulin 2010). However, demographic pressures have resulted in increased emphasis on health promotion and prevention, as articulated by the National Strategy for an Ageing Australia (Lewin and Vandermeulin 2010). A restorative approach to homecare has also recently emerged in New Zealand, described as imbuing a broader interpretation, focusing equally on quality improvement and promoting independence (King et al 2012b).

Service outcomes

There has been concern in relevant research to identify the extent to which home care re-ablement can reduce commissioned hours of home care for local authorities and realize overall efficiencies. Early work on restorative homecare developed in the US in response to findings that home care workers were often working at cross purposes with rehabilitation programmes, prompting a controlled trial which showed that restorative care reduced likelihood of visiting an emergency department and increased chance of staying at home, compared to usual homecare (Tinetti et al 2002).

Because early research on reablement was short-term (Ryburn et al 2009), a prospective longitudinal study was carried out by SPRU at the University of York and PSSRU at the University of Kent. This combined standardized outcome measures and qualitative data from staff, service users and carers, and found a significant decrease in subsequent social care use (Glendinning et al 2010). The SCIE review of the evidence (2011a) highlights this study as a significant improvement in the evidence base on reablement, while pointing to a number of limitations as acknowledged by the authors. This includes a need to fully consider the cost implications of unpaid care.

Colin Slasberg (2009) has urged a need for caution in evaluations of home care which compare outcomes of reablement against traditional home care, without taking into consideration the fact that those allocated a package of re-ablement are sometimes those thought to be most likely to benefit. More recent studies have included a randomized control trial from New Zealand (Lewin et al 2012) and a cluster randomized control trial from Australia (King et al 2012b) which showed reductions

in the need for ongoing home care and service efficacy. The primary measure of effectiveness in the New Zealand study was the need for ongoing personal care services (Lewin et al 2012). This evidence is currently being reviewed by a separate project at the University of Strathclyde.

Service outcomes will be revisited under the performance management section. Service outcomes such as care hours required post-intervention can be an important measure but a review of the evidence identified that they are sometimes used exclusively as a measure of success, (SCIE 2011a). It is also important to know whether the service improves outcomes for individuals.

Personal outcomes

Rather than simply measuring changes in the service, it has been argued that measuring the impact on people's wellbeing, or the 'final outcomes,' require attention to the individual's life (SCIE 2011a). The longitudinal study by SPRU/PSSRU found that although it did not improve self-perceived health, reablement was significantly associated with better health related quality of life and social care outcomes compared with use of conventional home care (Glendinning et al 2010). More recent research from New Zealand (King et al 2012b) and Australia (Lewin et al 2012) also found improvements in standardized functional and quality of life measures.

Some studies (Rabiee and Glendinning 2011, Wilde and Glendinning 2012) have emphasized that individual holistic outcomes should be included in reablement, underpinned by findings about the need to get the initial engagement with service users and carers right. Before further considering evidence about the critical role of assessment, support planning and personal outcomes in reablement, consideration will be given to the involvement of unpaid carers.

Involving Unpaid Carers

There has been limited research examining unpaid carer perspectives (Ryburn et al 2009). The SPRU/PSSRU study included ten carers who reported onerous responsibilities which did not diminish through reablement, although benefits included new skills and approaches to meeting the needs of the cared for persons (Glendinning et al 2010). It is argued that further involving unpaid carers in reablement could enhance carers' wellbeing and gains for people using the service (Wilde and Glendinning 2012). Reablement services could support carers more by recognizing their needs (perhaps by referral to support) and by providing advice on sustaining capabilities of the person using the service (Rabiee and Glendinning 2011).

The recent report by SCIE (2013) recommends that family and friends providing regular support should be involved in the assessment and development of the care plan and that there needs to be clarity about the role that these carers wish to provide.

Individual assessment and support planning

The prospective longitudinal study in England (CSED 2010) found limited evidence of people using the service being actively involved in the initial negotiation of reablement goals and outcomes, with many believing that the content of the service

was not up for discussion. A small number illustrated the value of clear early explanations and understandings of the aims of reablement, which enabled them to be involved in goal setting and increased their motivation to achieve goals. However, goal setting could be less appropriate for people with progressive conditions or who were adjusting to new permanent disability. It also required flexibility to take account of fluctuations in health or social contexts. The Welsh Reablement Alliance (2011) have argued that assessment for reablement must focus on enabling and empowering outcomes, in partnership with the individual and their family and should determine the content of the reablement service.

Specific recommendations on collaborative goal-setting have recently emerged from Australia and New Zealand. A review of the Australian and international evidence (Benevolent Society 2011) describes an approach to collaborative goal-setting which involves developing a list of goals which are ranked by the individual in importance, setting intermediate and long term goals: 'This approach of listing and ranking issues assists older people to set long-term goals and combines care planning and goal setting into one meaningful activity' (Benevolent Society 2011, 3).

Recent research in New Zealand considered the role of a designated tool to identify client directed goals in a sample of older people receiving home care (Parsons and Parsons 2012). The authors cite considerable evidence of the role of goal setting in effective rehabilitation and in enhancing patient-centredness. While identifying that active participation ensure a broader and integrated approach including family matters and psychosocial needs, they also highlight the complexity involved:

> However, goal-setting with older people requires a unique skill set and the increased prevalence of cognitive impairment, communication difficulties and multiple co-morbidities provide added complexity to the process (Parsons and Parsons 2012, 2).

Collaborative goal setting was a central feature of another New Zealand study (King et al 2012b) which led to development of personalized support plans, which may have contributed to improved mental health scores.

The Social Care Institute for Excellence (SCIE) (2013) have recently made recommendations on goal planning, advising that while there is no single universally accepted tool for goal-setting, focusing on people's strengths and what they want to be able to do is a good basis for the process. This guide also argues that goals must be person-centred and involve the individual as far as possible:

"It is therefore crucial that reablement managers and frontline workers have a clear understanding of the individual's priorities and the aspects of their life they believe are central to feeling 'independent'. If the person's own aspirations and definition of 'successful' reablement are not clearly understood, there is a risk they will become demoralised when they see they are not being helped to achieve their personal goals" (SCIE 2013, p13).

Relationships with staff

From the perspective of older people using reablement services, relationships with

staff are highlighted as of particular importance. As with conventional home care, people's experiences seem closely associated with the quality of the relationship they develop with their care workers (SCIE 2011a). Similarly, some of the adverse reports may apply to any home care service, such as handover points and limited support for domestic tasks, but reablement throws these issues into sharp focus because it emphasizes a handover after a certain period and that the goal is to encourage people to undertake their own domestic tasks (SCIE 2011a). This reinforces the need for reablement teams to manage people's expectations from the outset, explaining not only the particular ethos of reablement but also its boundaries in terms of the nature and length of support (SCIE 2011a).

Where particularly good relationships had developed, individuals described the care workers as having a positive motivating effect, encouraging their progress or improvement (Glendinning et al 2010). Knowing they were being regularly and frequently monitored and the routines created by regular reablement visits, boosted users confidence, especially after illness or hospitalization (Glendinning et al 2010).

The importance of relationships with reablement staff takes on particular significance in the case of individuals who are socially isolated. It is conceivable, particularly for isolated individuals, that a reduction in the amount of care worker visits might lower their sense of wellbeing (SCIE 2011a). However, although some people identified social contact as an agreed goal, there was little evidence they had received help with this (Glendinning et al 2010). Such individuals reported a high degree of loneliness resulting in loss and uncertainty at the end of the reablement period (Glendinning et al 2010). Socially isolated users could be unwilling to accept they could undertake tasks for themselves if this meant losing the contact of a home care visit (Glendinning and Newbronner 2008, Petch 2008). Curtailment of social participation has been found to induce involuntary withdrawal, which can result in functional decline and depression (Barnes and Frock 2003) and is therefore a key consideration for reablement.

Service intake and performance

No single leading model has yet been identified for reablement (SCIE 2011a). In general, two models of re-ablement are described as 'intake' and 'discharge support'. Intake services appear to take all individuals assessed as requiring re-ablement. Discharge process services can be more selective, accepting only those most likely to benefit. Research evidence suggests that there is often a pattern of agencies starting out on the reablement journey with a discharge model of provision, progressing onto an intake model once established (Lewin et al 2012, Rabiee and Glendinning 2011).

A strong link is emerging between decisions about who is admitted to reablement and the potential impact on performance figures. In one study, some managers identified that the move to a mainstream 'intake' model had created pressures on the service, as it significantly reduced the success rate demonstrated in the earlier pilot scheme.

> This has implications for how 'success' is defined, how service effectiveness is measured, what might be expected from reablement service and over what period of time. If policy makers and local politicians are only interested in dramatic impacts, then it will be hard to justify effectiveness for service users for whom success might be less visible and/or measurable in the short term

(Rabiee and Glendinning 2011, 501).

There are risks with a performance driven approach that could result in people who are capable of modest improvements being excluded (Rabiee and Glendinning 2011).

A note of caution has been raised in relation to the unintended impacts on existing users of traditional home care services, of the impact of reablement. Given that reablement services have largely developed inhouse, and are afforded far greater flexibility in terms of duration of visits than traditional home care, it is unsurprising that there has been critical feedback from people using traditional services. The evaluation of the service in Edinburgh picked up user feedback that the mainstream care worker was more pressurized as a result of having more clients to visit, a view confirmed by management (McLeod and Mair 2009).

Staff

In contrast to the extensive material available on implementation of reablement in the UK, there is a lack of detail on practice (SCIE 2011a), although it has been identified that staff and managers views about the impact of reablement on service users are generally positive (CSED 2007, SCIE 2011a). One of the key challenges for staff who have moved from traditional homecare to reablement has been the need to learn to 'step back' from helping service users, as well as to engage in goal setting.

One study emphasised the importance of regular team/peer support to keep staff informed and motivated, and supervision to reinforce the reablement approach in day to day practice. The importance of flexibility (including duration and frequency) and responsiveness to individuals' changing circumstances was highlighted (Rabiee and Glendinning 2011). Frontline staff had to have the freedom and opportunities to be creative to respond to user needs. Effective recording systems were essential to ensure communication between team members to deliver continuity in support – otherwise opportunities to build on and continue to encourage newly acquired skills could be lost (Rabiee and Glendinning 2011).

A recent study from New Zealand specifically addressed the perception of paid caregivers (King et al 2012a). This study usefully sets reablement in the context of the wider homecare service, which faces challenges in recruitment and retention of staff. Despite the increasing complexity of needs of community dwelling older people, wages remain low and working conditions poor (King et al, 2012a). Paid caregivers in both mainstream home care and restorative home care agreed that their relationships with the older people were the most rewarding part of the job, expressing concern about older people being socially isolated.

All paid caregivers reported issues in relation to working conditions, such as inadequate communication and support from the home support agency, no guaranteed hours of work, low wages and no reimbursement for travel time between visits. Many in the control group had thought of leaving for reasons associated with poor working conditions, particularly a lack of information about older people, which raised issues of safety for both staff and older people. Lack of support and supervision also led to unsafe working conditions for the control group. (King et al 2012a)

Higher job satisfaction rates in the intervention group were largely due to increased support from coordinators and improved training and flexibility. Compulsory fortnightly meetings improved satisfaction owing to information about performing tasks and conditions. Staff reported reduced isolation training in small groups, which also allowed them to speak up and ask questions. Flexibility of task was a large factor in job satisfaction, giving staff a sense of worth and self-confidence. The results corresponded with reduced turnover (King et al 2012a).

Role of OTs

A review of the role of OTs was undertaken by SCIE in association with the College of OTs (SCIE 2011b). OT strengths were identified in assessment and goal planning, and their ability to provide training to care workers was highlighted. Rapid access to OT therapy skills and equipment were viewed as essential to avoid delays (SCIE 2011b). Within an integrated team, the value of the profession's ability to transcend health and social care has been highlighted (Petch 2008).

Access to OTs was important to people using the service (Glendinning et al 2010). In one study it was identified that clients were particularly pleased at the speed with which any equipment they required was put in place (Mcleod and Mair 2009). Difficulties with accessing OTs was highlighted as a significant barrier in one study (Rabiee and Glendinning 2011). Some users expressed frustration about lack of access to other therapists, including physiotherapy, which impeded progress (Wilde and Glendinning 2012). The most recent review by SCIE (2013) reports continuing uncertainty however, as to the whether the service requires input from professional occupational therapists or whether it can be staffed by trained home care assistants.

Role of Commissioning

Commissioning needs to evolve to support sustainable outcomes in and around reablement, with barriers including inflexible contracts, funding arrangements which do not incentivize promotion of independence, a culture concerned with inputs rather than outcomes, and home care staff not trained in reablement (Slasberg 2009, Allen and Glasby 2011). In a recent guide produced in association with the UK Home Care Association, SCIE also advocate a new approach to commissioning.

> This is a clear departure from traditional commissioning arrangements and will require trust and transparency from both commissioner and provider to turn reablement from a threat to an opportunity (SCIE 2012, 2)

There is also the organizational matter of the need for capacity in the home care sector, as shortages delay discharge from reablement, blocking the service to new referrals (Rabiee and Glendinning 2010). Arguments for a shift in commissioning culture point to the need for a whole systems approach.

More recently, SCIE (2013) have emphasized the need for those making referrals to reablement (principally social workers) to include individual strengths in their assessments, that they have enough knowledge of reablement to describe its purpose have sufficient information about the outcomes of reablement to be able to convey hope about improving physical, social and/or psychological wellbeing.

Need for a reablement/whole culture

The potential benefits of a whole systems approach have been highlighted. This includes the need for clear articulation of the organisation's model and ethos of reablement which has to be more than a 'bolt-on' to the existing service. To achieve a person-centred and enabling culture requires that policy, practice, training, supervision and quality have to be clearly aligned with the agency's mission, vision, values and strategic direction (Benevolent Society 2011).

It is also clear that reablement services need to be well linked to the wider system of care and support (Rabiee and Glendinning 2011). As policy makers seek to develop a more preventative approach to older people's services, new policies and initiatives have contributed to this, but rebalancing the nature of the whole system remains elusive. It is argued that this illustrates the vicious circle of focusing on supported discharge (rehabilitation) rather than admission avoidance (prevention) (Allen and Glasby 2011). The risk of reablement achievements being undone is emphasized, through handover to a traditional home care service at the end (CSED 2007, Glendinning and Newbronner 2008, McLeod and Mair 2009).

> Managers from all four (re-ablement) sites reported that often when a service user moves from re-ablement to an on-going package of care provided by an independent care provider, they revert to having tasks done for them rather than being supported to undertake tasks themselves (CSED 2007, 29)

Arguing that reablement is a much bigger agenda than just creating dedicated services, Slasberg (2009) suggests that a change in focus from the provision of re-ablement services to the development of a re-ablement culture aimed at all service users is necessary, as the route to achieving the highest possible levels of independence. This reablement culture would ensure that mainstream services would be attuned to the reablement potential of all users and committed to achieve it.

> There is a growing body of evidence that changing the currency of contracting from outputs to outcomes holds the key to bringing about this kind of transformational change (Slasberg 2009, 146).

Reviewing the evidence for outcomes in reablement

It was notable that the literature discusses outcomes in two distinct ways. There tends to be a separation between the identification of goals at the outset of reablement, and identification of outcomes as a way of measuring the success of reablement at the end of the intervention. While the recent SCIE (2013) guide provides a very useful review of the evidence so far, it also separates initial goals and final outcomes, highlighting the importance of goal-setting with individuals in one section with a separate section titled 'Outcome measurement – what does successful reablement look like?' (p22). They recommend using both service outcomes such as a reduced package of care or no ongoing care, alongside validated outcomes measures such as ASCOT to measure personal outcomes such as accommodation cleanliness and control over daily life. The emphasis is on tools to measure outcomes post-intervention.

There is little reference to the potential to use personal outcomes as a means of *both* engaging individuals and their families in identifying the focus of the service intervention *and* as a means of assessing the effectiveness and impact of the service following intervention. However, a review of the literature presents a strong case from the perspectives of the various stakeholders involved, for inclusive, personal outcomes focused planning, as follows:

The case for personal outcomes focused planning, from different perspectives

Perspective of people using the service
Individuals need to understand from the outset the nature of home care reablement and what is expected from them (Glendinning and Newbronner 2008)
Having the motivation to maintain or regain skills is crucial (Glendinning and Newbronner 2008). Involvement in determining the focus of the intervention appears highly motivational in encouraging people to do more for themselves (CSED 2010).
There is recent emphasis on the need for those making referrals to reablement to include individual strengths in their assessments, and to be able to convey hope about improving physical, social and/or psychological wellbeing (SCIE 2013)
Although a focus on regaining physical ability is central, addressing psychological support to build confidence as well as social needs and related activities is also vitally important and often neglected (SCIE 2012).
If the person's own aspirations and definition of 'successful' reablement are not clearly understood, there is a risk they will become demoralised when they see they are not being helped to achieve their personal goals (SCIE 2013).
A focus on identifying and addressing quality of life outcomes might support a key concern of people using services in relation to the time limited nature of reablement and the potential for loneliness when the visits from staff end (Glendinning and Newbronner 2008, Petch 2008)
More modest achievements are still demonstrable through inclusion of personal outcomes, and there can be significant impacts on service user morale (Rabiee and Glendinning 2011)
Additional efforts might be required in cases where an individual has used conventional homecare, which could create resistance to change (Rabiee and Glendinning 2011)
When planning support with people living with dementia (including goal-setting), it is particularly important to see past their diagnosis and gain an in- depth understanding of the person (e.g. their interests, past jobs or hobbies, their family context and the things that motivate them) (SCIE 2013)
Perspective of unpaid carers
The importance of involving family members is emphasized by research showing that carers are sometimes resistant to reablement, preferring styles of intervention that minimize risk to older relatives (Rabiee and Glendinning 2010)
Family and friends who are involved in proving regular support should be involved in the assessment and development of the care plan and that there needs to be clarity about the role that these carers wish to provide (SCIE 2013)
Combined individual and family perspectives
There is a need to recognize that understandings and interpretations of 'independence' can vary and require exploration, particularly by understanding user and carer priorities (Wilde and Glendinning 2012)
Staff perspective

Home support staff have identified concerns about service user isolation. Systematic consideration of quality of life outcomes could reduce staff concerns in this regard (King et al, 2012a)
Service perspective
To support the required shift from focusing on task and time in homecare, reablement should be commissioned on the basis of the outcomes that the service will support the individual to achieve (SCIE 2012)
A key recommendation from SCIE's review is that the views of people using services and their unpaid carers should be systematically recorded (SCIE 2011a)
The inclusion of 'softer' outcomes might help to rebalance pressures to demonstrate hard service outcomes such as reduced service hours (Rabiee and Glendinning 2011)
Recent recommendations are that people should be assessed on the basis of their strengths without prejudice about potential to be included and that the objective may be more flexible about preserving and encouraging a more functional state than about independence (SCIE 2013)
Closer attention to service user priorities could yield a more holistic picture of needs and enhance service outcomes (Wilde and Glendinning (2012)

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Chapter Two: Stakeholder interviews

Following the literature review, nine individual interviews were held with stakeholders within North Lanarkshire Council, to gauge local perspectives of individuals in diverse positions of influence over reablement, to inform the knowledge exchange process. Potential interviewees were identified through discussion between the researcher and the service manager, on the basis that interviewees should have had either a significant influence in the development of the service and/or be involved in delivery of the service. Individuals were then approached initially by an administrator within the council, and invited to take part in an interview in a location convenient to them. Almost all interviewees who were approached agreed to be interviewed. There were two interviewees who initially agreed but were not included due to periods of leave during the interview period. These were an NHS manager and a service manager from the independent sector.

The nine interviewees included a strategic manager for older people's services, two Home Support Managers (one from reablement, one mainstream), the project lead for Reshaping Care for Older People, an OT, a Senior Officer for older people, two Service managers and a representative from Voice of Experience (VoE), the local user and carer representative organisation. To preserve anonymity, individuals are generally identified as strategic or operational managers. Occasional reference is made to the occupation of the respondent, where this is relevant to the comment made and unlikely to make the person identifiable. Where first names are mentioned, these are pseudonyms and have been used so that different contributions from individuals can be linked, without revealing their identity.

All interviews were undertaken by the researcher on North Lanarkshire premises, each lasting between 25 and 60 minutes. The interviewees were provided with an information sheet and consent form prior to interview and were offered the opportunity to ask any further questions at the start of the interview. Permission was sought in each case to audio record the interview. Each interviewee was asked about their role in relation to the reablement service, about their perspective on the role or potential role of an outcomes focus in the service and any barriers and supports to achieving that. Interviews were recorded and subsequently transcribed. Following completion of all interviews, the transcripts were coded manually by the researcher. This involved first reading the transcripts to get a sense of the content, and then re-reading the transcripts while noting codes in the margins. The themes identified below were distilled from reviewing the range of codes identified. The analysis was guided by, but not restricted to themes which had been highlighted in the literature review, with priority given to statements linked to the project priorities of engaging with people using services and their families, and identification of outcomes. Eleven themes emerged from the interview data, and each theme is discussed in turn below.

Introducing reablement/supporting independence

A strategic manager for services for older people described how the reablement idea had emerged within North Lanarkshire through a best value review undertaken in 2008, whereby the challenge was to achieve efficiencies while improving quality. A review of developments across the UK indicated that reablement presented as the one alternative that might work:

"And so we said, well actually this is the one thing that is new and it seemed to be addressing lots of different concerns. So there was the concern about overwhelming demand for future services and it was looking at that question and saying well some of the existing demand is actually unnecessary demand." (Strategic manager)

Another strategic manager described how local managers were encouraged by the positive reports emerging about improvements and efficiencies associated with reablement elsewhere, and that because Edinburgh was held up as a positive example within Scotland, a visit was made to see what was happening there.

While the first strategic manager was clear that the need to find efficiencies was a concern, there was also a commitment to maintain a focus on better outcomes for people using the service, fitting with the wider work on outcomes locally.

"The wider issue of looking at it from the perspective of service users, we were thinking that a lot of what we are doing in outcome based work is about promoting a sense of independence, a sense of control over one's life, a sense of engagement in one's own community" (Strategic manager)

The same manager acknowledged that in the early stages, the management team had concerns about how reablement would be viewed by the local population, as home support was known to be as a highly valued service. However, while aware there had been public concern following implementation, several managers highlighted the very recent positive results of a survey of people using the home support service:

"Earlier this year we did a survey and it matched as closely as possible a survey of service users that we did for the best value review…the percentage of satisfied and very satisfied has gone up compared to the survey 4 years ago, and the percentage of the group who identified…as having had a reablement service is actually higher than the main stream group so that is a hugely important finding for us" (Strategic manager)

The initial task required in trying to engage with all stakeholders and get information out to people about this new service was described as significant:

"So obviously there was a huge role in working with partners and getting the message out to partners about what we were doing, service users, carers, individuals, groups, primary care, as well as acute, linking in with them, as well as the massive job within our own authority and round the six localities speaking to different people about what the kind of vision for it was and how we could go about actually making it happen," (Strategic manager)

Support for reablement was evident in all nine interviews, albeit with reservations, as will be discussed below. Most interviewees referred to the importance of supporting independence through reablement. A home support manager was clear that reablement was the right way for home support to go. In fact, she likened the service to the old homemaker role, which supported people to achieve homemaking skills, which she felt had been lost in social work:

"I love reablement, absolutely, I don't know why they didn't bring it in earlier or they didn't even keep the kind of idea of the home makers going, so, yes I am all for reablement and how it works." (HSM)

A representative from a local organisation for people using services and carers described her own view of reablement positively. The views of this interviewee chimed with the strategic manager who wanted to ensure that unnecessary demand on the service was reduced, and the resource allocated to the people who need it most:

"I definitely see it as a positive development because I have spoken to support workers who have said they go in and they have a cup of tea with Jeanie for an hour and then they go in to someone else who needs a lot more intensive support, but they are only able to give them 15 minutes. I think through speaking to some of the home support workers they are also saying it is a better use of their time and they are happier as well so that the people who need it more are getting it," (Rep, VoE)

Who can be included in reablement

There was a sense across interviews that inclusion criteria for reablement are not hard and fast in North Lanarkshire. Several interviewees expressed a view that most people can benefit from reablement, albeit for some this might be to a limited extent. Both home support managers expressed the view that everyone is capable of doing something for themselves, even if just 'washing their own face.'

The OT explained how she makes decisions about whether to include an individual in reablement or not. She said that although willingness to participate is a factor, she tends to err on the side of including someone who is physically capable but less motivated, as there is potential to use prompting and encouragement to move the situation on with the person. The medical condition of the person would tend to be a bigger factor in decision-making. However, this was not always necessarily the case, as had happened in a visit immediately prior to the interview:

"I have just had an interesting conversation with the daughter of a service user who I am going out to review next week and although we both agree that there might not be a reduction in the time spent with her father she is quite keen for him to go through reablement because it would alter the way that time was spent with her father in a more beneficial way…. things like he was going for his newspaper and the corner shop is just next to his house, and he was doing that and he was speaking to people on the way, and he was speaking to the lady in the shop and he was getting quite a lot of social stimulation from that. But he has had a number of falls and the workers have decided, don't you do that and I will bring your paper in, in the morning but it is having a bigger detrimental effect on him," (OT)

The theme of motivation will be discussed further in the next and subsequent sections.

Initial engagement

Getting the initial engagement right with people using their services and families was a theme raised by several interviewees. The importance of individual motivation, and the need to consider psychological wellbeing as well as physical functioning in

reablement were referred to frequently. Two strategic managers discussed the need to work closely with people who might have capacity to regain skills, but for various reasons, including periods of depression or bereavements, lacked motivation.

While intake is broadly based on the initial visit by the Home Support Manager and/or the OT to a person being considered for reablement, this does not always necessarily happen in practice, due to staffing and scheduling pressures. While this was identified as an issue that needed to be addressed, there was also a view from the reablement HSM that because frontline staff spend more time getting to know individuals, they should have a role in establishing rapport and working with people to identify the potential benefits of reablement from the individual's perspective:

"The OT and myself can explain probably where reablement comes from and what the expectations are, but I think the home support workers can explain better to the service users, well this is why we are doing this so you can do this, this and this. They are on a more personal level explaining reablement whereas we are talking in general from a home support point of view" (HSM)

Resistance

Introducing a theme which was to remain constant throughout the project, several interviewees identified resistance to reablement they had encountered when introducing the concept to people for the first time:

"In North Lanarkshire… quite a lot of the resistance is actually from the families more than the service users… I think it is less now; to start with there was uproar with people saying that reablement was taking your service off you, and what not." (HSM)

Various reasons for this resistance to the new service were identified. Two strategic managers felt that home support is a very well established and valued service locally. Because the introduction of reablement coincided within the context of a global financial crisis, there were suspicions that the motivation for reablement was solely reductions in the home support service, with less understanding of the potential benefits. However, one strategic manager was clear that there was an issue about fair allocation of the resource. He recounted a conversation which illustrated this:

"There was a home support worker I spoke to and she said that she resents this service user, and she felt really bad about [that]. She did everything she could not to show it but she worried that he would sometimes know that she didn't like him... And she said that the reason she resented him was because she goes and does his shopping every single week on Tuesdays. And she is always in the same supermarket at the same time on a Thursday morning, and he is there helping his sister to do her shopping. And she said it is not his fault, and who I should be angry with is my manager and with the service because my time with him is wasted time because he could do his own shopping... So she was really so positive about the principle."

The representative from Voice of Experience felt that more information could have been made available to support this understanding:

"People were panicking and I think that it was because at the beginning there wasn't enough information being given out in terms of what reablement meant or what it would mean for the service user and the carer or the families." (Representative, VoE)

Several interviewees associated resistance to the service with the potential loss of the social contact provided by home support workers, a theme which will be revisited under social contact below.

Role of Occupational Therapy

The role of Occupational Therapy in the new reablement service was viewed positively by several interviewees. The ability to access equipment provided by OTs was highlighted by a HSM:

"It's amazing how having access to equipment can make such a difference. We can tap into the extra OT at the drop of a hat and they will come out to visit. Aids and adaptations open up all kinds of possibilities, for example, we have found that through provision of a bath chair someone might turn round to us and say that they no longer need support with bathing three times a week. Or something simple like a kettle tipper can give much more independence." (Mainstream HSM)

However, two strategic interviewees were keen to emphasise that the role of the OTs in reablement was more than provision of equipment. For one strategic manager, it was important that reablement provided OTs with an opportunity to engage more with supporting individual skills and the wider role that they had been trained for:

"I am aware of a critique, and OTs were the first to say themselves they had become focused on equipment and adaptations, they regularly told us that they were trained to do something totally different from what we as local authorities were asking them to do." (Strategic manager)

For another strategic manager, the role of OTs in developing people's potential was important not just to people using the service, but to the learning of other staff:

"Looking to find people's potential [has been part of the change] so I thought the OT in that was absolutely crucial. I still think there's been huge learning for staff working closely with OTs," (Strategic manager)

It was also identified that the role of the OT in identifying reablement goals and outcomes could be expanded, which will be discussed in the section on outcomes.

Training/Better working conditions

The importance of investment in staff training and support was a key theme. It was highlighted that in North Lanarkshire a decision was made early on to invest in reablement training for the entire in-house home support work force, including mainstream staff:

"Yeah, well…we trained the whole of the work force, we trained over a thousand workers, we developed a 3 day training program and everybody went through that and each locality has a reablement service," (Strategic Manager)

From the outset, the intention within North Lanarkshire has been to build the reablement ethos across the entire service, and there was universal support for this across interviewees. All staff were included in the reablement training in the early stages and this evaluated positively across both mainstream and reablement teams. While mainstream staff had had limited opportunities to use their training so far, plans to revisit the training in the context of other service changes were underway.

There was general recognition that the different structure and approach within reablement made a significant difference to working conditions for staff. One strategic manager thought that what made reablement more successful way of working was the conditions of working and the support for good practice:

"Part of me thinks reablement is a vehicle for embedding good practice," (Strategic manager)

Another strategic manager noted that many reablement staff had previously worked in mainstream, and that she could see how much they enjoyed being able to make their own decisions, and to have their suggestions valued. Recognition that the working conditions within reablement were having spin-off benefits both for staff and for people using the service had resulted in attempts to replicate some of the conditions within the mainstream service. This included trying to take caseload pressure away from team managers and OTs so that they could do joint visits with staff. There was a general sense of significant challenge in working out ways to expand the reablement ethos within the very different structure of the mainstream service:

"Well we are in the process of organising patch meetings with staff. We have had a few already but obviously we have had a high level of sickness, so obviously the placing has kind of taken over recently but what we do is we meet with the staff in small groups and we update them if there is anything new, like new mileage forms, if there are any changes in practice and procedures and it gives them the opportunity to raise any group issues." (Mainstream HSM, Locality B)

Two senior managers identified a concern to ensure that home support staff should be valued within the wider service. A commitment had been made prior to commencement of this project to further improve the annual staff roadshows, to be more celebratory of the service, and to give staff a voice. One manager viewed the roadshows as a success, particularly because home support workers were given roles as peer facilitators, making it easier for other staff to express their views. There was therefore a commitment to continuing the roadshows in a similar format in 2013.

Reversal of reablement goals

During the initial interviews, concern was expressed about the potential contradictions of running two different models of home support side by side. The implications of this were particularly apparent in North Lanarkshire because the reablement staff are still sometimes undertaking mainstream visits and they witness the reversal of goals

achieved in reablement once people return to mainstream. In particular, there was recognition that the current structure of the mainstream service presented real challenges to HSWs to be able to implement their reablement training. This theme was a particular concern for the two home support managers who were interviewed:

"And sometimes in here we are banging our heads against a brick wall, because my team will from time to time go back and visit old services users that we have had on reablement, that require some support maybe with their bathing or showering once a week, and we are going in and the home support worker is doing everything for them. That is when I find reablement difficult because almost every home support worker in this locality has had reablement training but it is down to time restrictions and if they do not have the time to wait until Mrs. so and so makes her tea… I don't think it is possible when you have got task and time" (HSM)

Both home support managers identified time as being the key factor in limiting the possibility for mainstream workers maintaining reablement goals:

"But I think time restrictions, that is a big factor. Because the reablement team do have a lot more time with the service users so they can encourage them to do so much more. Whereas with time restrictions, if workers have only got half an hour then they might be tempted to do things for somebody rather than encouraging them to do it together" (Mainstream HSM, Locality B)

Expanding reablement

Plans were being put in place for a significant expansion of reablement, as this project was starting. While most referrals were currently coming through hospital discharges, a strategic manager explained that one of the first proposals to be approved for reshaping care was to recruit additional OTs over two years to assist with reviewing everybody using mainstream home support, estimated at between 2,500 and 3000 people. This was followed by a proposal to recruit additional home support managers. The manager explained the need to expand the ethos, including concerns about the reversal of reablement:

"We are now rolling out reablement across home care, and we are rolling reablement to residential and short stay care homes. So we are rolling it out with the recognition that potentially lots of people are involved, and you don't want other bits of the system undermining the achievements, you want everybody working with one another" (Strategic Manager)

While there was overall support for extending reablement, there were also reservations about the potential for increased resistance from people using the service:

"Yeah it is going to be, it is more difficult for people who have known the traditional service. Some people will, we would have to be honest and say that we have actually created dependencies and not all of that will be able to be undone you know, so in terms of moving on to offering reablement to all of the service user population who predated the introduction of reablement, this is a different population and we don't expect to get the same results," (Strategic manager)

There was a concern at strategic and operational levels, that home support in general faces significant challenges in reconciling the levels of demand with the actual resource available, particularly as people with more complex needs come into the service.

Links to NHS

Links to the NHS were identified as important to reablement from various perspectives. At the strategic level, the need to transfer resources from the acute sector to the community was identified as necessary for reablement to expand. For one strategic manager, the Allied Health Professional delivery plan was promising in its intention to move health professional resource into the community, with possibilities for supporting independence more broadly, with better links to physiotherapy, podiatry and others.

There was also a need to promote better understanding of reablement within the NHS. Although a few interviewees identified the jointly NHS and local authority funded Community Assessment Rehabilitation Service (CARS) as a service which did understand reablement, further work was required to ensure that the wider NHS was informed and had a better understanding of reablement.

Embedding outcomes

Several interviewees identified that there was real potential to improve the focus on outcomes. Given that there was work going on in the wider social work service to implement the outcomes focused review, there was scope to build this in to reablement, with significant potential benefits for people using services. One manager was also clear that she wanted paperwork to support a further shift away from a task-oriented focus:

"And I think the kind of next stage for me in terms of reablement and outcomes is actually to begin to change all the paperwork and everything because our paperwork just reflects tasks so we have these aspirational statements that people are working towards but the day to day is all about tasks and we need to improve the language there" (Strategic Manager)

Individuals expressed various views about barriers they perceived for the different staff groupings involved, including occupational therapists (OTs), home support managers (HSMs) and home support workers (HSWs).

While the role of OTs was viewed positively in general terms, the use of the BARTHEL tool by OTs within reablement was not viewed as supportive of an holistic outcomes focus with a need to focus on quality of life as well as change outcomes within the service. There would need to be a period of negotiation if OTs were to move to broader outcomes focused assessment.

Two strategic managers identified that there could be particular challenges in engaging home support managers in identifying outcomes. The complexity of caseloads over recent years has significantly increased the administrative and IT requirements of the home support manager role, with limited time spent working

directly with people. Identifying outcomes would not therefore be a familiar part of the role, and that HSMs would require support to develop these additional skills.

There were also potential challenges in engaging home support staff in this agenda:

"It has to mean something to people or they are not going to buy into it. If they think it is something, oh that is for the professionally qualified staff and that doesn't mean anything because I am a home support worker and that does not apply to me and that is how you create that divide," (Strategic Manager)

There was a need to build the outcomes focus in different ways across the service:

"So you can pull people in for a day on outcomes training but that is going to make very little difference to them out in the field. How do we embed a whole programme change so that we are driving over a number of years through a number of different routes. So that is increased supervision of home support workers, and maybe outcomes in supervision [and in] patch meetings," (Strategic Manager)

Social Contact

The need for social contact for many more isolated individuals was broadly recognised as a key determining success factor in reablement:

"There is a minority of people who just don't want [reablement] and I am not sure how much we can do to change that. For some of those people it is about having the contact with people at home…We have one woman who has been through reablement twice but she is not going to sustain the skills because she wants the visits" (HSM)

"If I get reablement and it gets to a point where I don't need a home support worker, who is my contact with the outside world?" (Rep, VoE)

This was also recognised as an important factor for families:

"A lot of our older people are very socially isolated and a home support worker in a lot of cases is the only person they see and families are very, very worried that if we remove the home support worker that is going to leave mum, dad or whatever even more isolated," (Strategic Manager)

To some extent, this need was being addressed within the wider service:

"Back to what you were saying earlier, about making sure people aren't so socially isolated, we have got our locality link officer that will pop along to the meetings, she doesn't come along every week but she will maybe come along maybe every 3 or 4 weeks and we just go through each person and that gives the girls an opportunity to say then" (HSM, Locality B)

However, there was also broad agreement that further development was needed. The lead for RCOP informed that half a million pounds had been invested in community capacity building, with a mapping exercise underway across the six localities. This

work would build on existing structures such as the locality planning groups, using the locality link officers, but would result in new opportunities:

"Through reshaping care there is also a big project within the 6 localities it is called the Locality Partnership Development Programme… We are one of the six organisations that have been given money to do a specific piece of work in our area which is Airdrie and that consists of looking at what services are being provided in that locality now and where are the gaps," (Rep, VoE)

Performance management

Strategic managers expressed doubts about the national performance focus on hours of service saved by reablement, including whether the calculations were meaningful:

"If performance disproportionately emphasizes reduction in hours between the start and end of reablement, that risks inadvertently inflating the benefits. There are demonstrable savings, but you need sophisticated economic modeling to factor in the costs of the reablement model alongside the benefits" (Strategic manager)

Further, while current figures would suggest that a majority of people leave reablement with a reduced or no service, this would change with the expansion of the service to people who currently receive mainstream services. However, while there was recognition that this expansion might not produce the same reductions in hours of service, it was still necessary because there was a significant section of the caseload who had received home support for a long time, with relatively low levels of need. Capacity was needed for increasing numbers of people with higher levels of need.

One strategic manager was concerned that start-up costs were largely obtained by diverting resources from within the service, although in the longer term it was hoped that costs would balance out, as more people achieved independence:

"It is a more expensive service and it has been done with existing resources… and you have stressed the other bit of the service… and you would hope that in a year's time, that is kind of balanced out" (Strategic Manager)

While there were concerns that the start up costs had been significant and were not necessarily apparent in simplistic performance measures, there had been efforts to consider other measures to monitor costs and benefits:

"We are looking at ways to try to plan as effectively as possible. We have started measuring the number of double up visits in the mainstream service. The criteria for double ups are stringent and are a fairly good indicator of preventing admissions. We have noticed a significant increase in double ups in the last year and the fact that we are able to respond to that, we see as due to efficiencies being realized through reablement (Strategic Manager).

Discussion and conclusion

Initial interviews with stakeholders within North Lanarkshire council identified key themes. Some of these confirmed themes which had arisen through the literature

review, including the benefits of independence for individuals using the reablement service, the importance of training and good working conditions for reablement staff, the benefits of involving OTs, the need for good links to the NHS and an understanding within the NHS of the role of reablement. Themes which were less evident in the literature related more to the specific approach being adopted in North Lanarkshire and the focus of this project, on embedding outcomes in reablement. Interviewees were upfront in acknowledging the resistance they had encountered from people using the service and their families, and were clear about the need to engage with people at the outset, to consider quality of life outcomes and particularly social contact, in order to address this. There were also existing and new developments within North Lanarkshire which could support this, with emphasis on the role of locality link officers and the new work on community capacity building.

Also less evident in the literature was the theme of reablement being reversed when people move onto a mainstream home support service, where structural factors and limited resources mean that the potential for a reablement ethos is highly constrained. Although all home support staff had received reablement training in North Lanarkshire, the mainstream staff had not been able to put their training into practice, because they were still working in a service based on task and time. Constraints on the mainstream staff were particularly evident to reablement managers in North Lanarkshire, because their staff are working in both models simultaneously. This concern was also evident at strategic level, and serious consideration was being given to how to address this in creative ways, within the continuing resource constraints.

A further concern from several interviewees in North Lanarkshire was the predominant focus on hours saved by reablement. While the literature review did raise some doubts about this, managers in North Lanarkshire expanded on a number of concerns about the validity of costing assumptions, and the need to exercise caution with regard to planning of services. Again, the importance of identifying and measuring personal outcomes as a balance was highlighted.

Chapter Three: Focus Groups

Three focus groups were held between November 2012 and January 2013, each lasting between 50 and 75 minutes. One focus group was held with people using services and family carers in North Lanarkshire, and two with reablement staff. Towards the end of the project, a fourth meeting was held with older people using services and voluntary sector staff to check out some of the key findings and actions planned as a result of the project. The researcher facilitated the three focus groups and the final meeting with people using services, and the PI for the project co-facilitated the first two focus groups. Each discussion started with a review of the information and consent forms, which had been sent out in advance of the focus groups, and there was an opportunity provided to read these documents and ask any questions. Permission was sought to audio record the discussion.

There then followed an introduction as to the purpose of the project, to embed personal outcomes in reablement. Key messages were revisited about the potential benefits of including a focus on the priorities of each individual from the outset of the reablement service. Each focus group was guided by a limited number of questions centering on individuals' roles and experiences in relation to reablement, views about embedding outcomes in reablement, and any barriers or supports to this.

Each discussion was recorded and transcribed, and once the focus groups were completed, the transcripts were coded manually by the researcher. This involved first reading the whole transcript to get a sense of the content, and then re-reading the transcripts while noting codes in the margins. In order to verify the validity of the themes identified, another researcher from Strathclyde University separately coded the transcripts. This researcher was conducting a literature review on reablement for the Scottish Government. There was a high degree of correspondence between the two sets of codes which emerged, with some modifications made. The changes mainly resulted in more detail being added to the coding frame. The themes below were distilled from reviewing the range of codes identified. The analysis was guided by, but not restricted to themes which had been highlighted in the literature review, with priority given to statements which linked to the project priorities of engaging with people using services and their families and identification of outcomes.

There were six themes common to all three focus groups: supporting independence, initial engagement, assessment, having enough time, knowing the medical condition and social contact. There was one additional theme for the group of people using services and carers, linked to social contact, which was participation. There were five additional themes for the staff groups: who can be included in reablement, motivation/resistance, better working conditions, co-ordination with other services and the need for longer term monitoring of outcomes for people using the service.

Focus group with people using services and carers

One focus group was held with people using services and family carers. A total of ten people took part, mainly from Coatbridge and Airdrie, but also other parts of North Lanarkshire. Many participants were using multiple services, including day services, mainstream home support, condition specific support groups and informal services such as church groups. A few people were also involved in providing support to

others via voluntary work and caring roles. The focus group was arranged by a worker for the Voice of Experience Forum, who participated, along with a Co-ordinator for the Parkinsons self-help group. The second focus group at the end of the project involved two people using services, the development worker from the Voice of Experience and a worker from community capacity building. Although the two older participants in the group were users of services in their own right, they were also very active in supporting other older people in the community.

It is important to note that in the first focus group only half of the ten participants had direct experience of reablement, either in their own right or as a carer. Although some of the comments reflect general experience of services, all participants understood the concept of reablement.

The comments have been altered in some cases to remove identifying information. The names have also been changed to preserve anonymity.

Supporting independence

Having spent some time at the start of the focus group discussing the concept of reablement, several participants commented on the importance of maintaining independence. For one individual this was clearly associated with dignity:

"They encourage them to do more for themselves and keep your dignity… [I know about this] through listening when I am at different organisations" (Joan)

Maintaining independence was also associated with a sense of achievement:

"I don't let anyone do anything for me that I can do myself. I even have a stool when I go and do my washing. I feel as if I have done something when I do that. I don't need someone else to do that. It makes me feel good" (Betty)

While everyone who commented on this thought that maintaining independence was valuable, a related theme was the variation identified by several participants in their day-to-day ability to manage:

"We want to be independent but there are things, you know your limits. I suffer from heart failure. Some days great, some days rubbish." (Betty)

Initial engagement

A key theme for this group was the importance of initial engagement with home support services. Participants who expressed a view reported that they did not always feel sufficiently involved in decision-making about what the home support service did.

"That is kind of the problem here, they kind of make the decision for you and you don't get asked" (Joe)

A clear distinction was drawn between home support staff and managers

"My biggest problem is the ones in charge, not the carers. They come in and tell you how you are feeling and what they expect from you." (Betty)

Home support workers were on the whole viewed positively by the group. Participants who commented described their carers as 'lovely' or commented that they had 'been lucky' with their carers. When asked what it was about the carers that the liked one person commented:

"They are kind girls. Yesterday I wasn't feeling good. Carol made a cup of tea and put my feet on the stool and said I will put the keys through the door and I will see you next week." (Joan)

The following comment also illustrates a view that people should be treated as individuals by home support managers:

"Every person is different but they don't look at it that way. They see "oh, it's alright for this one, so this one will get it" and everyone gets the same thing." (Betty)

Assessment

In general, members of this group did not specifically raise assessment as an issue. The key concern identified was generally about the need to be involved in decision-making. However, one of the support workers made the following observation as to how information-gathering in the early stages of reablement could be improved:

"They shouldn't be afraid of building up a relationship with people because then they will understand what people need to support them – you won't get that in one initial visit because a lot of the times you are on your guard and you don't want to say too much. But you should have more than one visit as it's the only way you are going to get a true picture" (Susan)

Having enough time

Although most views expressed about home support workers were positive, there was a shared perception that the carers did not always have enough time.

"They haven't got enough staff…. The girls are run off their feet." (Joan)

The same individual explained that she had struggled to cope on return home after ten weeks in hospital. She had been advised on the phone that the carer would be coming in for forty minutes and was hoping for help with cleaning her fridge which was in a poor state, and with putting her clothes away. When the carer turned up she had only twenty minutes and was unable to help with the clothes. While Joan did manage to put her clothes away, this took a long time to manage on her own.

The service knowing your condition

Several participants were concerned that home support, including reablement, sometimes did not know enough about their medical condition. They felt that the staff should have access to their medical information, raising questions about whether and

how information is shared across different services. One woman had been disappointed because the reablement team had found out information about her medical condition when they visited her for the first time, and she felt that this had resulted in a decision that she should be referred to mainstream home support instead.

Social contact/participation

The importance of social contact was discussed by this group, although to a lesser extent than some of the other themes. This may well be due to the fact that all participants were well connected to a range of groups. When one female who goes to day services twice a week, and has done for several years, was asked what made it good, the answer was clear "company". Another female participant described her participation in groups as a "lifeline," particularly as she had no family.

The theme of social contact was discussed more at the meeting held at the end of the project, for people using services to give feedback on the plan. All four participants at that meeting described their roles in supporting others who were socially isolated, either through their paid job or through volunteering.

Focus groups with reablement teams

Two focus groups were held with locality reablement teams. Participants were recruited via the local manager for the service and the facilitators were given locations and times for the groups. The localities will be referred to as Area A and Area B. Locality B had been established earlier, and had been operational for more than three years, while Locality A had been set up about a year later. Locality A included the HSM, OT, 3 HSWs and the admin worker, and Locality B included 3 HSWs initially, with a fourth arriving halfway through. All participants were female.

It is important to note that both teams were initially set up as reablement specific teams. Staff in both teams had previously worked in the mainstream service, sometimes for many years, and described how they had had to learn to step back at first in reablement, in order to support people to do things for themselves. However, more recently, given shortfalls in the mainstream service, all staff had experience of simultaneously working between mainstream and reablement. This provided a sharp focus on the difference between the services and most significantly, the impact on individuals using the service when they are transferred from reablement back to mainstream, as will be discussed below.

Supporting independence

Staff in both teams also identified that they saw benefits from reablement. In particular, they enjoyed seeing individuals regaining skills and confidence. However, they also identified that the individual needed to be motivated to achieve independence as identified in the following comment from Locality B:

"There is some people who want to be independent and they don't want home care in but there is some people who do. We still work with the people who don't, we try and say this is for your benefit"

The importance of motivation was highlighted as a necessary ingredient by both staff groups, and will be discussed further in the section on motivation and resistance.

Initial engagement

Both reablement teams made connections between the approach adopted in initially engaging with individuals, and the success or otherwise of reablement. One of the key differences evident between the two teams was the role of the manager. Team A described a situation where they had had less stable management, with changes of manager and a recent period of not having a manager in place. In these circumstances, the initial visits which should have been undertaken by the home support manager and/or the OT had not been taking place routinely.

Although a manager had been newly appointed at the time the focus group was held, the staff explained how they thought that it would make their job easier if the managers and OTs were consistently going in to do the first visit, and explain reablement, particularly for people moving from mainstream. These preparatory visits were particularly important because the home support staff said that they couldn't cover everything in the introductory visits: getting to know the person, explaining reablement and providing a reablement service.

Assessment

One of the purposes of reablement is to provide an extended period of assessment, during the time-limited intervention, of usually up to around six weeks. While key points in the assessment will be the start and end points of the service, there is also a place for ongoing information gathering. In Locality A, it was identified that the ongoing assessment in reablement results in a more individualised intervention, as compared to mainstream, where knowledge of the individual is limited:

"You don't get the same information on mainstream either, you're going in blind. You have got to take time and read the care plan get to know them. Whereas reablement, you know from the start as you have done the joint assessment and you meet every week and discuss everything that is happening." (HSM, Locality A)

In Locality A, although there was a sense that the introductory visits by the HSM and OT were usually taking place, there was also a view that one visit was not enough to get to know the person. The manager identified the significant role of home support staff in continuing to build a picture of the person:

"The girls will know as well, as they are in, they get to know the family and what they used to do and then they come back and build a bigger picture." (HSM, Locality A)

One of the home support workers reinforced this view:

"We build a relationship, it is a trusting relationship so that they will tell us that wee bit more and we can identify more that is going on round about with the whole house rather than just the person and everybody going into the house as well, we do get a bigger picture... I think what most of us tend to do is go in, the first two days and get to know them before we do any work with them" (Yolanda, Locality A)

However, while this information was built up over time between the teams, it was not clear whether or where this information was being routinely recorded

Having enough time

Both reablement teams identified the importance of time for successful reablement.

"I feel that you get a wee bit longer time. When they work on mainstream, the girls don't get the time to do what you would want with reablement." (OT, Locality A)

Both teams also identified the lack of time in mainstream as the critical factor in preventing a reablement approach being adopted more widely:

"We are given an hour to work with somebody, so we are given a point to where they are happy doing as much for themselves as they possibly can and then we get took out after six weeks and mainstream will go and they get put in and their times are limited and ours weren't. And over a period, could be a couple of months down the line, that person is practically back at the very beginning." (Debbie, Locality A)

The HSM in Locality A was concerned for her staff in terms of the disappointment they experience when they see their reablement work being undone with the mainstream service. She described ways in which she had tried to resolve this:

"What we try and do is called a handover. I will try and give a manager a week to two weeks notice to say this person will be coming to you long term, if you could identify permanent workers and our girls will meet with them for two days for a handover to see how they have been working but that doesn't work either." (HSM, Locality A)

Knowing the medical condition

In both localities, home support staff discussed the importance of understanding people's medical conditions, in order to know how much the individual can be expected to do for themselves, as illustrated by the following discussion in locality B:

> Anne: Sometimes we have had people and we know we can't push them until somebody comes and says, "Right, you can do that with them." It depends on what they have been in hospital with…and you know you better not push in case something happens to that person…"

> Lynn: Sometimes we have got to ask [the OT], we will ask if they could go out and visit them… Sometimes, when we have our weekly meeting and if we are unsure we will ask for someone to go out as quick as to see if you think they are ok.

> Jane: We don't want to just take that on yourself, if you are not sure.

The team in Locality A discussed medical conditions they had encountered and how as a team they had tried to understand how best to work with individuals. One team member described her learning in relation to working with someone with depression:

"I had a client with depression. I think you have got to understand it, it is a difficult thing to understand and you are going in and their physical ability looks fine and it's their mental health that you are working on. It can be quite hard as they are up and down so every day is like a new challenge going into work with someone in that way." (Yolanda, Locality A)

However, this team found the mutual support available to them through team meetings invaluable:

"And if we come across something that is new to each other, we talk about it and get the information across. We get to know the signs and know what we are looking for just through talking, but in mainstream you don't get that." (Ann, Locality A)

While there was general support for having access to medical information, there was also a cautionary note about preserving confidentiality:

"You have got to be careful what you put on the goal plans because they are in somebody's house, who have maybe had drug or alcohol problems that impact now on how they do things. You have got to be awful careful as anyone can read them. Which is why your meetings during the week is where all that information is passed." (OT, Locality A)

Social Contact

Both teams referred to the importance of social contact for people using services. This was viewed as a factor behind some of the resistance to going onto reablement. In locality A, the team identified that they would try to make relevant referrals for individuals who are isolated:

"If we feel that someone is sitting in the house and not socially included, then the girls are really good at coming back and we have got a girl in here. who is the locality link officer… and we are good at getting her involved as well." (HSM, Locality A)

However the team would have no knowledge in the longer term of what the continuing story was for the individual

Additional themes from staff focus groups

There were five additional themes from the focus groups with staff.

Who should be included in reablement

Most staff interpreted the principles of reablement quite broadly as meaning that everyone is capable of doing something for themselves, and should be supported to do so. This was influenced by staff knowledge of the mainstream service, whereby they see that individuals have things done for them, even when this is not always necessary. Therefore the challenge is partly about bringing elements of the enabling approach in reablement into the mainstream services.

"Obviously there is some people that wouldn't be able to work reablement but my argument is that everyone can do something and should be timetabled to do something, whether it just be wash their face or brush their teeth, even though everything else is done for them." (HSM, Locality A)

In locality A, staff were more aware of planned changes to the home support service, including the intention to extend the reablement approach to people already using mainstream home support. Staff also described circumstances where they felt individuals had been referred to reablement inappropriately, such as at the end stages of life. Meanwhile staff in Locality B described circumstances where individuals had been referred to the team because there was no space in the mainstream service. This meant that they were providing a 'holding' service until space did emerge. Overall there was a sense that the criteria were shifting and that there would be a need to revisit inclusion criteria over time

The second staff specific theme which was important to both staff groups, but particularly to group B, was the issue of meeting resistance to the reablement service.

Motivation/Resistance

Staff emphasized the importance of individual motivation to engage with reablement. One HSW in Locality B described how she had visited an older man who had recently been through reablement and was now receiving a mainstream service. His wife had spent the previous three days trying to persuade him to get washed and dressed:

"I said "Come on then, let's get you washed and dressed" and he said "Nae bother" and his wife couldn't believe it as she has been trying for 3 days."

Although the reablement worker was now visiting him on a mainstream schedule, she persuaded him to re-engage with his goals, illustrating the influence that staff can have on individual motivation. The importance of motivation was also emphasized by Team A, who described circumstances where they had used persuasion and clear direction to encourage people to undertake a range of tasks

Both teams also described resistance they faced from individuals they had worked with in reablement, particularly where the people involved had previously had a mainstream service. Families were described as being more resistant than people using the service:

"A lot of families are scared that we are taking what their parents need" (Yolanda, Locality A)

This was a bigger theme in the focus group in Locality B, where participants were struggling with what they described as 'backlash' from people. Staff in this group felt that they were regarded more negatively in reablement, largely influenced by the expectations families had as a result through previously using the mainstream service:

> Jane: I found it quite hard to start with actually, because you were that used to doing everything for everybody. And taking that initial step back, the people we were going to were used to everything being done for them.

Anne: I felt as if some were very confrontational. This lady told me "I'm used to getting my lunch on my tray" and I am thinking, well I know that that and that is what you are use to getting but that is not going to happen…. You felt awful. I felt like some people's families hated you.

Participants expressed understanding for the family reluctance to lose the service:

"They don't want the service taken away as they know, if they are at work and the family member is being visited four times a day then they know they are fine, which is understandable as well." (Jane, Locality B)

While all staff understood that the overall intention within North Lanarkshire is to include some level of reablement within the mainstream service, and were supportive in principle, they described the challenge of putting that into practice, when people using the service are used to the more traditional model of service delivery:

"When we go into mainstream, we are told to take the reablement approach still but it is just sometimes it's not worth the hassle the mouthful you get." (Lynn, Locality B)

Better working conditions

In addition to the extra time available in reablement, staff within both localities identified other improved working conditions, such as weekly team meetings, as well as opportunities to stay in touch with each other between meetings. This was particularly evident in Locality A:

"We have probably got a better relationship with each other as well because of the weekly meeting and it's a trust thing." (Debbie, Locality A)

The same team discussed how this increased their commitment to their jobs. They also saw the role of the manager as being critical. However, while opportunities for team working and relationship building were valued, there was concern in both teams about the perceptions of them by mainstream workers, who sometimes believe reablement staff are better paid, and are taking clients from the mainstream service:

"Some home support workers resent reablement as well because they think they have lost their clients, they think we are taking their jobs" (HSM, Locality A)

Locality B started working in reablement earlier than Locality A. This team had an opportunity in the early days to manage their own schedules. The staff described the advantages of this autonomy, and how they could use the time flexibly. As the service came under pressure to fill gaps in mainstream scheduling, this autonomy was lost, impacting on morale. Additionally, they identified that because people using the service were informed of specific allocated time slots, this made it challenging to work flexibly, because individuals expect the visit to last for the scheduled time, even where staff felt the time could be better used elsewhere.

Co-ordination with other services

Both reablement teams identified other services which had emerged locally, with broadly similar remits of supporting people to stay at home. The main services identified were ASSET (Age Specialist Service Emergency Team), an NHS led service, and CARS (Community Assessment and Rehabilitation Service), a jointly funded NHS and local authority service. In both localities, the development of CARS in particular had proven challenging initially as the respective teams tried to negotiate their roles and responsibilities, with some duplication in the early stages.

Need for follow up of people using the service

In Locality A, there was particularly strong support for an outcomes approach in reablement. The manager of this team identified a need for longer term monitoring of outcomes for people using the reablement service. This manager was not convinced that the emphasis on measuring the success of reablement on the basis of reduced hours, was a reliable indicator of what is really going on:

"We give them the stats and they look great, the girls have done their job. We have started off with someone who needs a 30 hour service and maybe we have got them down to about 7 or 8 hour service. So when it goes over, everyone is genuine and have done a really good job. But see if you would have probably went back and looked at that, it would have probably creeped right back up again. It probably would have had an increase." (HSM, Locality A)

The concern to monitor individuals longer term was prompted by two concerns. The first was the perception of members of the team that a significant number of people using home support were socially isolated, and that unless they had opportunities for social participation in the community, their wellbeing and functioning might reduce longer term. The second concern was based on staff seeing individuals moving from reablement to a mainstream service, where time and resource limitations were preventing continuation of reablement goals, and the need to address this.

Discussion and Conclusion

Within the focus groups held in the early stages of the project, there was a high level of congruence between the themes identified. As in the interviews, there was overall support from all participants for the primary objective of reablement, to support independence through recovery/development of skills and confidence. For people using services however, there was concern that the service should recognize that their abilities might fluctuate from day to day, and that a flexible approach was required.

There was overall recognition that this was a significantly different way of working from traditional mainstream home support, and each group emphasised the importance of getting the initial engagement right. From the perspective of people using the service and their families, this meant the service manager in particular should treat them as individuals, and involve them in decision-making about what the service does with them. From the perspective of the teams, this meant that each team member had a role to play in the early stages. While home support staff were keen that the manager and/or OT have a clear role in explaining reablement and working out the role of the

service, there was also recognition from all team members that home support staff had an ongoing role in getting to know the person and building a fuller picture over time. There was some concern in both reablement teams about the need for clarity about the roles of NHS and jointly funded services providing support to keep/return people at home. While there had been some confusion and role duplication while the services were emerging, it was noted that it could be of significant benefit to have clear individual outcomes and goals which were shared across services.

Reflecting concerns in the reablement literature, time and the need for flexibility were central theme in all three focus groups. In the focus group for people using the home support service and families, there was a perception that there were limits to what could be achieved under strict time constraints. Meanwhile staff were clear that additional time was a critical factor in any successes achieved by reablement, and conversely, that attempts to extend the ethos into the mainstream service would always be hindered without more time.

There was a concern in all three focus groups that access to medical information was important for effective reablement. For staff, lack of information meant challenges in working out the limits and possibilities of their roles, and concerns that they might push an individual beyond what was reasonable or safe. The team manager and OT who participated identified that this information was not always available to them either. For people using the service this led to uncertainty about what service might be appropriate to them, and whether the teams were able to make these decisions.

Social contact was the final theme to be covered across all three groups. This was a concern for staff who regularly work with isolated individuals, particularly for people who rely on the service for company, and for families who rely on the service to keep an eye on their relatives. They linked this concern to the resistance to reablement they had witnessed repeatedly. This concern about longer term quality of life was a key reason why staff supported the plan for a stronger focus on outcomes and follow up for people months after leaving the service.

Among the themes identified only by staff groups, the importance of improved working conditions was emphasized as an important factor in the success of reablement. Staff identified that they were able to build relationships and trust with each other, through team working, team meetings, and ongoing contact between meetings, which improved communication and knowledge across the team, consequently improving service delivery. There were however differences between the two teams. Team A seemed to be particularly cohesive. All staff categories were represented in the focus group and all contributed to the discussion. Although both teams were concerned about resistance to reablement from people and their families, this was less of a concern for Team A, who had more of a focus on the need to monitor outcomes for people using reablement services in the longer term. While Team B had experienced less stable management, they were however hopeful that new managers would improve their working conditions.

Chapter Four: Residential Retreat

This phase of the project consisted of the residential event held over a day and a half in New Lanark. The invitation to the retreat had been produced by the researcher, in consultation with the three members of the psychology project team, and the service manager, who all also attended. Most delegates attended on both days, either on a residential or non-residential basis. The majority of delegates were members of the reablement teams who participated in the focus groups, including home support workers (HSW) home support managers (HSM) and occupational therapists (OT). There were also several managerial staff from the council including two senior officers for older people and a locality social work manager. A total of 23 delegates from the council attended, along with the researcher and the director of IRISS.

This chapter has been adapted from a report on the retreat, which was shared with North Lanarkshire a few months after the retreat took place. The report is different from previous chapters in that it provides an account of an event as well as reporting on findings. The early section of this chapter reports on each input and exercise undertaken, while the later and main section identifies key themes which arose from the discussion groups, recorded under separate headings. The main section includes several individual stories which staff told to illustrate what was working well and less well in reablement, and several of these are included as examples.

The retreat: Welcome and introductions

Opening by Alison Petch, Director of the Institute for Research and Innovation in Social Services (IRISS)

The event was opened by Professor Alison Petch, who welcomed everyone. Alison emphasised the importance of hearing from the delegates about their perspectives on reablement in North Lanarkshire as an essential step in building a focus on personal outcomes into reablement practice. Alison was also to open proceedings on the second morning when she recapped on the key findings from day one. This was really helpful in summarizing the key challenges and strengths which were identified on day one, and to refocus attention on the role of outcomes in reablement.

Scene setting by Jenny Hutton, Service Manager for home support in North Lanarkshire

Jenny followed by describing two parallel projects which had started around the same time, the ESRC project to embed personal outcomes in reablement and the psychology capacity building project, confirming the importance of the two related projects which were collaborating to support a focus on outcomes in reablement.

Jenny then provided an update on the results of the roadshows held with all home support staff in 2012. The roadshows adopted an innovative approach, which sought to capture the views of home support staff on what they needed to support them in their jobs. This information had been taken into consideration as part of the redesign of the service. Jenny was able to confirm that proposals from the roadshows had been approved, with key developments highlighted as follows.

- Longstanding concerns about pay differentials between Grade 1 and Grade 2 staff have been addressed, with agreement that all staff will be classified at a single grade, NLC3 (formerly Grade 2).

- A key part of the service redesign is the developing career structure, with opportunities for office-based management, in the form of home support co-ordinators and for charge hand senior support workers.

- In the next 3 years there would be a £3million investment in home support – including 22 home support co-ordinators, taking the pressure off the Home Support Managers in mainstream home support.

- The other main investment was to involve more staff on the ground, as the service moves towards working with service users with more complex needs.

Focus on personal outcomes by Emma Miller, Sr. Research Associate, Glasgow School of Social Work

Emma began by emphasizing that the event was part of a project about knowledge exchange, which starts from the view that if research is to have impact, it is essential to take account of the complexity of practice settings and to include a range of perspectives, including practitioner wisdom.

Emma briefly reviewed some of the evidence about personal outcomes, acknowledging strong links between the objectives of reablement and a personal outcomes approach. These included a focus on the role of the person in achieving their outcomes; the importance of involving individuals and families in planning; and the importance of tracking and reviewing progress towards outcomes. There was discussion about the significant challenge that has been identified in shifting *from outputs* or what services do, *to outcomes*, which is the purpose of activity or interventions. There then followed an exercise where all delegates spent half an hour in pairs, discussing outcomes that were important to them in their lives

Example of personal outcomes identified by delegates

Building personal confidence (towards a better job)

Developing trusting relationships through being able to listen

Staying healthy through achieving a better work/life balance

Deep relaxation contributing to improved wellbeing (via a holiday in Turkey)

Improved ability to cope through my daughter sleeping through the night

Peaceful, relaxed existence/wellbeing through resolving housing issues

Improving relationships and wellbeing through negotiating a stressful life event

Developing adult relationships with my children

Achieve a balance between work and family and achieve reduced stress through forward planning

Knowing my family is settled and well and at the same time developing my confidence (towards getting a new job)

Emma identified that this exercise was often useful for staff who were new to an outcomes approach, and that it was unusual for all delegates to identify personal outcomes in the way this group had managed to do. Often people identify the holiday or the new job as the outcome, instead of the impact on the person. The other useful part of the exercise is to highlight that outcomes for staff are often very similar to people using services. As one delegate noted: *'It's just life, isn't it?'*

Groupwork

The main body of the event consisted of three discussion sessions, two in the first day and one on the second morning, with delegates in two groups representing a mix of all staff. Group facilitation and note-taking were undertaken by the researcher and members of the psychology team. The researcher subsequently pulled together the main themes arising from these discussions as outlined below.

Key themes identified during the retreat

The importance of time

There were two ways in which time was highlighted as an issue by all sectors of staff. The first issue was about spending time with individuals. It was identified that OTs and HSMs in particular are struggling to find sufficient time to undertake good quality meetings with individuals, particularly at the start of reablement. It was widely acknowledged that early time investment can have a significant impact on whether individuals and families engage with reablement. Jenny confirmed that part of the rationale for the redesign is to create more time and space for home support managers in particular, but hopefully at least to some extent, for all home support staff

Example: I can think of one woman who was severely overweight. There were so many professionals involved. If you had read the notes you would see that she had been written off, and the way it was described was judgemental about it being 'her choice'. The staff spent time getting to know her and there was a story behind it all of her mother falling ill, she then lost her job from looking after her mother, and nobody had got in about that. See if it takes weeks just to get them to engage, that is an outcome.

The second issue was about the duration of reablement. Members of the management team were keen to reassure home support staff and managers that the idea of six weeks is indicative and is an average figure, rather than there being an expectation that this was the limit. It was also identified that it was important that people using the service should not be told that reablement would necessarily end at six weeks, as this can raise anxieties. There was some discussion about the need to build trust in some cases, before an individual could begin to make progress.

Understanding of reablement by other professionals and agencies

There was some concern that different professionals are still not clear what reablement is, including care managers and district nurses. Some teams have experience of district nurses phoning up to check why home support is not making breakfast for an individual. And although there has been progress, hospitals are still sometimes promising four times a day packages as a matter of routine.

A further concern was the need to discuss the role of the private sector. A senior manager was concerned that if home support is to become more outcomes focused, then independent providers would need to go through that change too.

Scheduling and IT

Home support workers from one team were concerned that they had lost control of their schedules, as identified during the earlier focus group. As the first reablement team to start, they had initially worked in patches and managed their list of referrals to make the most of their time. This was no longer the case and the staff believed this was reducing efficiency and effectiveness. The HSM confirmed that this had changed because the visits had to be recorded on the computer.

A Senior Manager commented that IT was necessary because the hours delivered every week had to be logged to feed various system information requirements. While there were regrets that IT demands sometimes significantly influence the way the service operates, there was also recognition that IT is a required to run the service, and that this needed to continue to evolve.

Working between mainstream and reablement

There was overwhelming support from all delegates for the rebranding of mainstream and reablement home support as one service. One option could be to rebrand as short and long-term reablement. Another option could be to adopt a new term such as supported living. There were several key reasons for this.

Reversal of goals: A key continuing concern for reablement staff is the unlearning of reablement skills when individuals go onto the mainstream service, and the associated need to adopt a more reabling approach across the service:

"We build their confidence, then we go back in and do a pop-in 3-4 weeks later and we then see that the mood is going back down as things are not maintained for them"

Greater flexibility: It was identified that sometimes people referred to reablement might benefit from a period on returning home from hospital, when they could recover and adjust to being at home before setting reablement goals.

Because reablement staff are plugging gaps in mainstream provision they sometimes find themselves being pulled between what are currently two distinct ways of working. One HSW described how she struggled recently to balance two roles:

Example: "I was in visiting a new lady in reablement – who was under adult protection. I only had half an hour with her and then went to work on a mainstream double up. But I wasn't happy leaving that lady so went back to her then away again on another mainstream case and then back again. It was my decision to go back. I just didn't feel happy leaving her".

<u>Removing divisions between staff:</u> There was a concern that mainstream staff need to feel valued. Some HSWs were concerned that their mainstream colleagues resented them and believed they had higher pay, which was not the case.

"Do we need to rebrand it? What we all do is reablement but what the team does is extended assessment and we have more time to do the job. Maybe we should design and rebrand the whole thing."

There was a view that the news announced by Jenny to regrade all staff at the same level would help with this:

"The change in funding so that there won't be Grade 1 any more should make a real difference in reducing the barriers between staff."

Training and support for mainstream staff

> *If you don't use it, you lose it.*

There was recognition that although mainstream staff had received reablement training two years ago, most had had limited opportunity to put it into practice and there was a need to revisit this. Modeling and shadowing were generally viewed positively by delegates, as means of learning new reablement ways of working. This could involve both HSWs shadowing each other and the same for HSMs. One HSM described how they had used this approach to support a shift in practice locally:

"We are supporting mainstream workers in a local patch to work in a reablement way, pairing up workers for shadowing in the very short term until they get the hang of it. The mainstream workers really appreciate the opportunity to work in this way and see the benefits. We are keeping in touch with the workers by phone and some have been able to come to meetings."

Although senior managers were concerned that resource limitations meant that the full range of working conditions for reablement could not be extended across the entire service, there was general support for extending patch meetings, smaller teams, more hands on support from HSMs and time for handovers to mainstream staff.

Quality of life of people using the service

"If we take the service out people say they are going to be very lonely, and it is not easy to walk away from it."

A theme returned to throughout the event was the need to focus on the quality of life of service users in addition to the goals and skills of reablement.

Example: We supported a man towards being able to walk to the lunch club, but our worry was that he would not able to continue with the lunch club when he went on to mainstream, because mainstream can't do that, and we would love to have been able to do something about that. We need it to be more outcomes focused i.e. to get out and about, but that isn't covered

Other examples were identified where teams regretted not being able to support activities like taking someone shopping. However the service manager emphasised that this type of activity was not out of bounds for home support. In addition there was a need to link in with the developing community capacity work, because teams would need to know what was available in their locality.

Example: We worked with a woman who was working towards washing and dressing herself. The difficulty was that although she made real progress, this took a long time and tired her out. What she really wanted was to conserve her energy to then do things that she wanted to enjoy. The difficulty with the system though is that if you can dress independently then you don't need the service.

This example prompted discussion about the need to ensure that as full a picture should be painted as possible, to help understand the complexity of people's lives and to make sure that the national measure of hours of service reduced by reablement was balanced by this information. It was argued that this type of case required a preventative approach, putting the resources in now to give the individual more time to develop their skills at a pace to suit them.

Recognising the full value of the work

> *We need to capture the valuable work that goes above and beyond.*

There was a widespread view that it was important for reablement to be able to demonstrate its successes, to support the public and other professionals and agencies to understand what reablement actually does (and doesn't do). Examples highlighted the importance of building relationships with the person and their family, in improving outcomes and supporting people to remain at home. A concern of managers was that skilled and complex work was not sufficiently recognised:

Example: With one woman, reablement is looking at a lot of different things. We were put in to assess how she is. We went in everyday and talked to her. Through spending the time with the lady and her son we have learned so much about her but we have also turned her son's values and beliefs around. We gave proper explanations to the son and we are now getting in help for her Alzheimers. And that is really skilled work [that the team is doing], and at the moment that work is not captured.

Example: One family case came in as child protection, and we knew it needed to be the parents that we worked with on their organisational skills, but there is no way to record this. This will be long term, these workers going in for a day every week for a year, and where can the value be shown?

As well as stories, capturing and recording outcomes would help with building evidence as to effectiveness. There was strong support for the suggestion from a

home support worker for follow up visits. While three month follow up visits were happening on a limited basis, there was agreement that this should be done consistently. There was general support for a common approach across services so that outcomes could be tracked over time and across the system.

The tool

The second group discussion involved examination of a draft outcomes tool for reablement, which had been produced by the service manager and psychology team in consultation with colleagues. As with the introduction of any tool, there was concern about the risks of duplication and for ensuring a good fit with existing processes. However the potential for the focus on outcomes to address many other concerns was also evident, including improved engagement with individuals and families, a focus on quality of life and the potential to build evidence about reablement.

The language used in care planning was identified as a very important issue. Getting it right meant avoiding jargon and using everyday words that made sense to people. Specific suggestions included asking the individual about what a typical day would look like for them. But further, there was also a need for flexibility: "You need to change language with every service user you go into."

The importance of developing trust was emphasized, and the need to gather the information over several visits. It was also important to acknowledge that not everything that mattered was about improvements, but that sometimes maintaining a situation could be a significant achievement.

There was some concern about the proposal to include a numerical scale in the tool. One senior manager highlighted the need to ensure that the importance of listening to people and good conversations were not eclipsed by a focus on scales.

The role of different team members in care planning

There was general agreement that the home support workers know service users better than anyone in the system, and that it is important their knowledge is captured in recording systems. There were different views among the HSWs about whether they might contribute to care planning, with some feeling they already contribute through team meetings. One HSW made the following suggestion:

"If the service user doesn't know the manager – why not take the HSW who knows the person to their review? The HSW can give a fuller picture and even if the person is having a bad day on the day of the review, they can remind them that they had been doing much better in the days before that."

While there was interest among HSWs in taking part in initial visits and reviews, not all staff wanted to be directly involved in care planning, particularly recording: "I feel awkward writing in someone's house – I want to maintain eye contact."

Further to this, one HSW emphasized limits as to how far the role could be extended: "But we are just support workers, we are not psychologists."

The role of the HSM was emphasized by HSWs, who felt that the initial visit was a key opportunity to clarify both the situation of the individual which might impact on reablement goals, and to explain the role of reablement to the person and their family. Where this wasn't currently happening this had repercussions for everyone and for the potential success of reablement. There was also a view among HSMs and senior managers that it was critical that HSMs needed to know the people using their service.

There was discussion about the role of OTs. A key concern for senior managers is that OTs are a limited resource who cannot contribute to every review. The service manager suggested that one way of dealing with the scarcity of OTs was that HSMs might do the overall assessment, in at least some cases working with a HSW, which would include identifying broader outcomes, while the OT would focus on goal setting. This presented a challenge from an OT perspective, due to a desire to stay involved with holistic assessment and the building of therapeutic relationships. OTs and home support managers aim to have joint visits for the exit interview. In practice, sometimes OTs completed these visits alone to identify whether goals have been achieved and the information is then passed onto the home support manager who maintain links with people going onto mainstream.

Developments in wider care management were identified as important, and one senior manager identified the need to link up assessments in different parts of the system. Another senior manager at the event had designed a flowchart in the early stages of developing the reablement service. There was agreement that it was time to review the flow chart, based on current knowledge of how the system was working.

Key messages from the event evaluation

At the end of the event, all delegates were provided with a sheet of paper and asked to identify what they found most and least helpful about the event, as well as what else needed to happen to embed outcomes in reablement. Delegates were not asked to provide their names on the evaluation sheets, but were encouraged to identify their occupation if they felt comfortable to do so. The aspect most frequently identified as helpful was the opportunity for staff at all levels to contribute to the discussion. HSWs in particular identified that they enjoyed being involved in an event which might potentially influence service developments, with several commenting that they felt their input was valued. HSWs appreciated the information which was provided by the service manager about planned changes for the service. There was enthusiasm for the proposed rebranding and the potential to get rid of the 'them and us' culture between reablement and mainstream. HSWs also identified two key aspects of the event which they found less helpful, including discussion about the wider politics of the service, and the discussion about the tool. Although some HSWs identified that they did not see the tool as something they would directly contribute to, one home support worker said that she found this the most helpful aspect of the event, in improving her understanding about how information was recorded and shared.

All delegates identified what else needs to happen, with the main themes as follows:
- Better communication between staff across the service (most common theme)
- Produce a plan from this event and share widely across the service
- Further consider how best to incorporate the views of all staff in care planning
- Rebranding of the service

- More time for staff and managers
- Communicate to staff and the public the messages about outcomes
- Improve staff knowledge about community resources to address quality of life
- Retrain the workforce, especially mainstream staff, including shadowing
- Opportunities for different localities to meet up to share best practice

Following the retreat the researcher drew together the main themes, informed by the interviews and focus groups to produce a brief summary plan for further embedding outcomes. This was shared and agreed with the service manager, psychology team and two strategic managers, resulting in amendments to the plan as follows:

Proposed plan to embed outcomes

Objective	Intended outcome	Action underway	Further action
Reduce gap between reablement and mainstream	Ensure staff and service user skills and confidence are maintained across the service	Revisiting training for mainstream staff Staff all regraded the same	Rebrand the service Use roadshows to promote outcomes and share best practice
Expand capacity within mainstream service	All staff feel valued and skilled HSMs able to work directly with users and staff	Employing 22 HSMs and 35 HSMs to relieve pressure on mainstream	Consider potential for shadowing/mentoring Ensure patch mtgs held
Increase outcomes focus	Ensure quality of life of people using service Improve confidence & independence of individuals Improve evidence and therefore wider understanding and potential of reablement	Design of tool to fit with wider care management work Psychology project developing links and protocols to build capacity of teams in engaging families	Training on outcomes to be delivered Further development of the psychology capacity building project in year 2 Share info on community capacity with all staff
Optimise team involvement in care planning	Maximise understanding of the individual and family to ensure the best quality of life and independence possible	Some HSWs already contributing to care planning	Further consideration to how to make best use of each team member, freeing up some capacity including HSWs

Chapter Five: Working with the Changing Context

In the introduction to this report, it was identified that when this project started there were significant changes taking place or planned within North Lanarkshire, which were to influence the direction of the project. This chapter will describe four key initiatives in turn, outlining any challenges and opportunities for the project, as well as impact on and interaction with the project aims.

1) The psychology capacity building project

Between the period of applying to the ESRC for funding for this project, and the award being granted, the service manager for home support developed an application for funding from the Change Fund within North Lanarkshire, to fund a psychology capacity building project for home support and community rehabilitation services. The rationale was that relevant teams did not have access to psychological expertise, despite psychosocial factors being central to individuals' engagement with services and their motivation/confidence/belief in their ability to adhere to interventions. The proposal was therefore to appoint a Senior Health Psychologist and Two 'Stage 2' Health Psychology Trainees to develop a Health Psychology Service. It was anticipated that over a two year period the three full-time psychologists would:

- Develop and advise on screening for psychological problems that may be barriers to engaging with reablement.
- Develop Health Behaviour Change Training, and associated resources for staff
- Provide a Consultancy service for staff on psychosocial issues relating to rehabilitation/reablement
- Develop guidelines/tools for use in the assessment and review process to focus on, and prioritise, personal outcomes and quality of life.

An overall aim was to enhance the efficacy of relevant services by providing psychological expertise to teams, developing screening tools to address barriers to engaging with reablement and up-skilling staff in the use of health behaviour change and communication skills and techniques. These were principally to produce tools and guidance to identify and prioritise outcomes and quality of life.

Challenges and opportunities

When funding was obtained for the ESRC project to go ahead, the funding for the psychology project had also just been agreed, with the scheduled start date for the one year ESRC project in September 2012 to be followed quickly by the two year psychology project in October 2012. Some initial challenges identified by the researcher centred on those objectives of the two projects which were the same. While this was a source of some initial concern, a series of meetings and conversations with the psychology team in the early stages helped to clarify how the two projects might complement one another and potentially achieve benefits greater than the sum of their constituent parts. The ESRC project involved one third of a researcher post for one year as compared to three posts for two years in the psychology project. Therefore the focus had to be on making best use of the researcher's limited time. It was identified that while the ESRC project would focus

on embedding the 'broad brush strokes' of an outcomes approach within reablement, the psychology project would provide skills and techniques for teams to drill down in their engagement with people using the service and their families. There was therefore potential for the two projects to build capacity in tandem.

Impact on and interaction wtih the ESRC project

The biggest change to the project was that the emphasis on developing a tool and guidance became more of a focus of the psychology project. The service manager took the lead role in the development of a draft tool. Although this created some initial concern about the ESRC project objectives, there were two key factors which reduced this concern. The first reason was that discussions relating to a second initiative within North Lanarkshire suggested that wider changes would have a significant impact on tool development overall within the council, as detailed under initiative 2. Secondly, wider work on embedding outcomes in services has demonstrated that the tools involved are only one component and that it is at least as important to focus on practice. Ultimately the shift away from the tool as the endpoint allowed space to explore wider issues around embedding outcomes, as detailed in this report. Additionally, several meetings were organized during the early stages to develop a consistent understanding of outcomes across the two projects, bringing in an additional knowledge exchange component.

2) Assessment and care management in North Lanarkshire

As identified in the introduction, North Lanarkshire was a very early implementer of outcomes based assessment in Scotland. The focus in the early years was on outcomes focused practice, with considerable investment in staff development programmes, involving initially social work staff and subsequently a range of NHS colleagues. Outcomes focused assessment tools were developed by the council for all social work services, followed by development of the outcomes focused plan. In the last two years attention has shifted to the outcomes focused review. Although this has been delayed due to having to compete with a number of contending workstreams, its launch was beginning to be implemented during the course of this project. A meeting with the lead for assessment and care management confirmed that the intention was that any other outcomes focused tools would need to fit with the new review.

Challenges and opportunities

It was clear that any tool for reablement would need to fit closely with the review tool being implemented across the authority. This was a challenge because the pace of implementation was slow due to system glitches. However, as identified above, given wider evidence that outcomes focused practice requires energy and attention over time, the shift in focus away from the tool provided opportunities to engage with practitioners in a sector which has had limited exposure to personal outcomes.

Impact on and interaction with the ESRC project

The key impact of the development of the outcomes focused review in North Lanarkshire was to further shift attention of the project away from tool development, which was now happening elsewhere, enabling a wider focus on identifying other

changes required and decisions which needed to be made to support the embedding of outcomes in practice. Therefore, for example, while a draft tool was discussed at the retreat, the discussions were much broader than the tool, and the event resulted in a plan of action covering a wider range of factors which required to be addressed, as illustrated in the table at the end of chapter four: *Proposed plan to embed outcomes*
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3) Restructuring of the home support service

The home support service in North Lanarkshire embarked upon a period of significant change following the best value review in 2009. The key changes had been the setting up of reablement teams within each locality, starting in 2010, and the introduction of an overnight service. Alongside these structural changes were commitments to improve supervision and support of staff and to increase the focus on outcomes within home support. There was also a commitment to prioritise and undertake individual reviews with more people using the existing service. The commitment to undertake reviews had recently been strengthened by the plan to increase the numbers of people referred to reablement from within existing users of the mainstream service. Therefore significant investment was being made in employing temporary home support managers and OTs specifically to undertake reviews.

A further change underway was a shift in focus in the annual home support roadshows. These roadshows were designed as a means of engaging with the home support workforce across the six localities in North Lanarkshire. The key objective in 2012 was to use the roadshows as an opportunity to celebrate good practice and to engage directly with the workforce to find out more about the outcomes important to them. The importance of being treated with dignity and respect emerged as strong themes for staff, and an action plan was developed to address the themes identified. A brief account of the approach undertaken is available as a case study in a guide previously produced by IRISS (Miller and Daly 2012).

Challenges and opportunities

The key challenge presented by the ongoing restructuring of home support was that there were more moving parts surrounding the project, including the raft of new temporary managers and OTs, and the undertaking of significant numbers of reviews. While this large-scale review process was being conducted at pace and for a specific purpomse, the project remained focused on the two established teams. The key opportunity arising from changes to the service was the annual roadshows, which became linked to the project in two ways. The messages presented to the home support staff at the start of this project's residential retreat were in part a response to issues raised at the previous roadshows, particularly in relation to improved working conditions and re-grading. Secondly, following from the residential retreat, the home support service manager made a commitment to emphasise outcomes in the 2013 roadshows, as part of the celebration of good practice.

Impact on and interaction with the ESRC project

The restructuring of home support meant that a number of change processes were being implemented in parallel. This meant that at times, the project was competing for attention in a fairly crowded landscape of change. Evidence from embedding

outcomes in other sectors highlights the importance of recognizing and addressing outcomes for staff if they are being asked to focus on outcomes for people using the service (Cook and Miller 2012). Linking of messages between the annual roadshows and the residential retreat for this project afforded opportunities to highlight the importance of outcomes for people and their families alongside the emerging dignity and respect agenda for staff.

4) Community capacity building project

North Lanarkshire has a range of initiatives underway under the banner of Reshaping Care of Older People. This includes significant investment in building capacity of informal resources to support the quality of life of older people living in the community. A large scale mapping exercise was underway during the project lifespan and it was anticipated that this would be completed about the same time. The purpose of the mapping exercise, was to clarify existing resources and to make this information more easily available to people living in the community and to staff about the range of available supports. A further purpose was to avoid duplication of services and to make sure that any gaps were identified and addressed. Further details of this initiative are available in Chapter One, via the representative of Voice of Experience who discussed the initiative in her interview for this project.

Challenges and opportunities

The mapping exercise presented a significant opportunity for this project. Evidence from embedding outcomes in other sectors has shown that practitioners sometimes lack confidence in undertaking outcomes focused conversations with people using services, if they feel that individuals might raise issues which may be challenging to address (Cook and Miller 2012). While this raises wider issues about the need to recognize the importance of conversations as potentially beneficial in their own right, it is also the case that knowledge of low-level community based supports can be very helpful in considering quality of life outcomes such as social contact and meaningful activities.

Impact on and interaction with the ESRC project

At the residential retreat there was significant interest from delegates when they heard about the developing work on community capacity. Following from the retreat, there was a commitment from within the service to ensure that the information resulting from the mapping exercise would be made available to the home support service. There was also considerable interest in community capacity building at the meeting held for people using services at the end the project. While there was general support for increasing the role of volunteers, and particularly older volunteers, there was also a cautionary note from an older male member of the group who described how he had found himself in a compromising situation through volunteering. This indivdiual was keen to emphasise the need for ongoing support for volunteers.

A member of staff involved in community capacity building described a variety of services which were being developed, with significant emphasis on befriending and volunteering, with new training for older people as volunteers. There is also a new i-

pad buddy scheme, whereby volunteers go into individuals' homes to teach them how to use the i-pad. This group was very supportive of these developments.

Discussion

The four initiatives described here were among a variety of changes taking place during the duration of the project, and have been highlighted in this chapter because they all influenced the direction of the project in various ways. Perhaps of most immediate significance were the first and second initiatives which both resulted in a re-direction away from tool development as a primary objective of the project. While initially presenting as a challenge, it quickly became clear that the move away from the tool as the focus was creating space to explore other areas which needed attention to support a focus on outcomes in reablement.

Following the residential retreat, activity continued to progress the focus on outcomes within North Lanarkshire, and the plan which emerged from this was the focus of continuing discussion for the project. Four months after the retreat, a further meeting was held to the plan was reviewed as follows:

Four month review of plan to embed outcomes

Objective	*Intended outcome*	*Action underway*	*Further action*
Reduce gap between reablement and mainstream services	Ensure staff skills and confidence are maintained across the service, which in turn will impact on maintaining service user skills and confidence	Revisiting training for mainstream staff Staff regraded as equals 2013 Roadshows used to promote outcomes and share best practice	Rebrand the service in the longer term, in line with integration of home support services with NHS
Expand capacity within mainstream service	All staff feel valued HSMs able to work directly with users and staff, rather than restricted to desk based work	Employing 22 OTs and 35 HSMs (some temporary) to relieve pressure Patch meetings increasing Shadowing/mentoring for HSMs through pilot	Consider potential to expand shadowing/ mentoring to home support staff
Increase outcomes focus	Ensure quality of life of people using service Improve confidence & independence of individuals Improve evidence and therefore wider understanding and	Design of support planning tool to fit with wider care management work Psychology project building capacity of staff teams in engaging families	Training on outcomes to be delivered Further development of the psychology capacity building project in year two Share info on community capacity

	potential of reablement		with all staff
Optimise team involvement in care planning/ review	Improve understanding and involvement of the person and family to maximise quality of life and independence	Piloting underway in Locality B involving 6 individuals initially, and deploying team members differently to ensure outcomes and goals identified	Pilot results will inform wider roll out of new approach to initial engagement, identification of outcomes and ongoing reablement assessment

At the last meeting for the ESRC project, it was confirmed that a pilot was about to take place in one of the two reablement teams involved. This pilot would pick up on many of the themes identified through the project, with a strong focus on the initial visits to people being referred for reablement, and the identification of outcomes.

The first visit would be undertaken by the Home Support Manager, and a social worker. As social workers in North Lanarkshire already undertake outcomes focused assessment and planning, this would provide an opportunity for shadowing/mentoring and capacity building. This initial visit would be focused on getting to know the individual, to consider their quality of life as well as their motivation and interests. The initial visit would also provide an opportunity to introduce the concept of reablement. It is anticipated that the majority of people interviewed will go on to reablement at this stage, and in any case the person should still have an outcomes focused plan. For people with dementia the plan is to re-establish patterns and ensure consistency. The psychology capacity building project will continue to support skills for outcomes focused conversations over the next year. This includes communication skills, motivation and identification of psychological barriers. They have developed easily accessible information sheets to support this capacity building and are working in patches across reablement and mainstream teams, starting with Locality B.

Following the first visit, the occupational therapist will then visit to set reablement goals with the individual, consistent with the overall outcomes identified. At this stage links can be made with the CARS team, which can bring in additional expertise as required, including potentially physiotherapy. This also helps to ensure that there is a shared understanding of goals and outcomes.

Following the period of reablement, the OT will revisit to assess progress of reablement goals and finally the HSM will visit to review the overall outcomes. Where it is considered likely that the person will cross over to the mainstream service, the reablement HSM will conduct this visit with the mainstream HSM. This is to support continuation of reablement principles.

The intention is to conduct a further outcomes focused review three months after the end of reablement, involving both the HSM and OT. This will consider both whether reablement goals have been maintained and the quality of life of the individual.

Discussion and Conclusion

This knowledge exchange project set out with the aim of embedding personal outcomes within the reablement service in North Lanarkshire Council. In this concluding section the findings of the project will be discussed in two parts. The first part considers the findings about the potential benefits of an outcomes approach in this sector, as well as factors identified as supporting and hindering the implementation. The second part more directly considers findings pertinent to knowledge exchange specifically, in discussing learning about the interchange between research, policy and practice in relation to the embedding of outcomes in reablement.

1) The case for outcomes in reablement

Expectations/Motivation/Resistance to reablement

At each stage of this project, all stakeholders expressed support for reablement as a concept, albeit with reservations in some cases. For people using services and carers who participated, there was support for maximizing independence, which was associated with dignity and having a sense of achievement. However, it was also identified that a flexible approach is required by home support, to allow for variations in individuals' day to day ability to manage.

The importance of individual motivation as a requirement to successful reablement was highlighted in the literature, with emphasis on the importance of clear explanations and opportunities to be involved in goal-setting. There were limited references to the potential for resistance to reablement from individuals and families (Rabiee and Glendinning 2011). However, this issue emerged as a significant concern during this project, amongst strategic as well as operational managers, but mainly for the frontline teams, one of which described 'backlash' they had experienced from people and their families. Staff identified how expectations of the service had a very significant bearing on whether individuals were motivated to participate, and that people who had previously had a mainstream service were therefore less likely to engage Expectation management needs significant attention in the context of reablement, and this project reinforces the need identified in some studies for reablement teams to manage people's expectations from the outset, explaining both the reablement ethos and the limits in terms of the nature and length of support (SCIE 2011a). It also reinforces the potential value of an outcomes approach, through investigating and seeking to establish the priorities of the individual.

Outcomes focused engagement/assessment

Considering the messages from the literature review and this project overall, the importance of getting the engagement with individuals right, emerges as a critical factor to the success of reablement. The prospective longitudinal study in England (CSED 2010) found limited evidence of service users being actively involved in the initial negotiation of reablement goals and outcomes, with many believing that the content of the service was not up for discussion. Given the significant concern of reablement teams involved in this study, around the level of resistance encountered in working with individuals and especially families, this is of particular concern.

People using home support services and their families reported that they wanted to be more involved in decision-making about their home support service. While this group valued independence and linked it to dignity, they also wanted recognition that their health might vary from day to day, requiring flexibility from the service. There was a high degree of correspondence between this group and the two staff focus groups on this theme. Both reablement teams made connections between the approach adopted in engaging with individuals, and the success or otherwise of reablement. The role of the manager was identified as critical, in ensuring that expectations were managed and a clear understanding reached of the purpose of the service. It was also recognised that a flexible approach was required: "You need to change language with every service user you go into."

Supporting Home Support Staff

There was a high degree of correspondence with the recent findings of research in New Zealand on the importance of improved working conditions for home support staff, in supporting successful reablement (King et al 2012a). In North Lanarkshire, the importance of investment in staff training and support was a key theme arising in interviews, focus groups and the retreat. In addition to the extra time available, staff in both reablement teams identified that they were able to build relationships and trust with each other, through team meetings, and ongoing contact between meetings, which improved communication and knowledge across the team, consequently improving service delivery. In Locality A, where there was stable management, the team described the role of their manager as critical, both in supporting them in their roles and in introducing reablement effectively to people using the service

Training for staff was an important issue both in the literature and in this project. In North Lanarkshire, when consideration was given to developing a reablement service from 2009, a decision was made to invest in reablement training for the entire in-house home support work force. The original intention was that the reablement ethos should be present across the service. On reflection in interviews, strategic managers acknowledged that the timing of this broad delivery of training had not been ideal, with limited opportunities for mainstream staff to use their training to date. Despite the significant challenges in extending the reablement ethos across the service, recognition of the benefits both for staff and for people using the service had resulted in continuing attempts to replicate some of the improved working conditions within the mainstream service. This included trying to take caseload pressure away from team managers and OTs so that they could do joint visits with home support staff. The staff roadshows were being used as a means to engage staff and to build morale.

Having enough time was identified as critical by all three focus groups. At the retreat there were two ways in which time was highlighted as an issue by all staff. It was identified that OTs and HSMs in particular are struggling to find sufficient time to undertake good quality home visits, particularly at the start of reablement with implications for managing expectations, reaching a shared understanding of independence, and motivating individuals to participate. A key consideration in the service redesign is to create more time for home support managers. The second issue with time was about staff having enough time to spend with individuals to support reablement goals. There was shared recognition that without more time in the mainstream service, maintaining reablement goals would remain elusive.

A reablement culture

Some sections of the literature urge caution on the establishment of distinct reablement services, arguing that they need to be well linked to the wider system of care and support (Rabiee and Glendinning 2011). The risk of reablement achievements being undone is emphasized, through handover to a traditional home care service at the end (CSED 2007, Glendinning and Newbronner 2008, McLeod and Mair 2009). Slasberg (2009) suggests that a change in focus from the provision of re-ablement services to the development of a re-ablement culture aimed at all service users is necessary, as the route to achieving the highest possible levels of independence.

Although effort has been invested in North Lanarkshire in providing reablement training to all staff, and in trying to build an ethos across the service, the mainstream service largely runs on a task and time model. The contradictions of running two models of home support side by side were evident. Reablement staff in North Lanarkshire are brought into fill gaps in mainstream schedules and they described seeing individuals they have worked with in reablement, whose skills have been lost on return to mainstream. The reversal of reablement skills is thrown into sharp relief, with consequences for staff morale. Time was identified as the biggest factor in this. At the residential retreat there was strong support from all delegates for the rebranding of mainstream and reablement home support as one service. For the present, the proposal to rebrand the service has been put to one side. In the context of health and social care integration, consideration needs to be given to how home support services should be branded as a whole, with potential to reduce duplication if this is done well.

Recognition of this contradiction in North Lanarkshire is driving efforts to bring down barriers between the mainstream and reablement service. Strategies include the extension of patch meetings, to reduce the isolation of the mainstream workforce and ensure that information about the direction of the service is better communicated. The capacity offered by additional HSMs and OTs is partly motivated by recognition that mainstream staff need better access to frontline managers in order to access support and advice when needed. This extra capacity is also intended to support more effective engagement with people using the service at an early stage of involvement.

This need for a reablement culture has most recently been reinforced by a report produced by NICE just as this project was concluding.

> There was wide agreement across the groups that it was imperative for [reablement] to be included but broad consensus - and strong feeling - that reablement and homecare cannot be distinguished from one another, i.e. that reablement ought to be considered as an outcome and philosophy that should underpin all aspects and stages of homecare (NICE 2013, 2).

Performance

The literature on reablement identifies that there has been an overall tendency to measure the performance of the service in terms of service outcomes, principally home care hours saved. This approach to measuring performance fits more with a discharge model of reablement, as when the focus is on people coming out of hospital

the chances of reducing the hours of service is higher. It is argued that if policy makers are only interested in dramatic impacts, it will be harder to justify effectiveness for people for whom success might be more modest/less visible, yet who could still obtain significant benefits (Rabiee and Glendinning 2011, 501).

With regard to outcomes focused practice, the importance of performance frameworks has been highlighted elsewhere (Miller 2011). It is well known that rigid performance measures can have adverse consequences for people using service in particular. With regard to reablement, an overemphasis on hours saved carries potential to limit the growing of an overall reablement culture, which has been identified as necessary in North Lanarkshire to avoid the achievements of reablement being reversed when people move on to a mainstream model.

In North Lanarkshire it is recognized that a focus on personal outcomes could provide the richer picture and understanding of the wider impact of reablement, as recommended by SCIE and others. There was a widespread view, particularly evident at the residential retreat, that it was also important for reablement to be able to demonstrate its successes, to support the public and other professionals and agencies to understand what reablement actually does (and doesn't do). A further concern of operational managers in particular was that the skilled and complex work undertaken by home support staff is not sufficiently recorded and recognized.

In Locality A, there was strong support for an outcomes approach in reablement, not just to ensure that the quality of life of people using the service is taken into consideration, but also to build a better picture of what happens to people in the longer term. The manager of this team was concerned about follow up for individuals who went on to have no service, to ensure that they were still coping. Equally, given the concerns about the observed tendency for people going onto a mainstream service to lose the skills and confidence they had developed on reablement, this manager was keen to see ongoing monitoring of people going on to a mainstream service.

Having considered some of the evidence and learning emerging from this project, consideration will now be given to the successes or otherwise of the knowledge exchange aspects, particularly in relation to the overall aims and objectives.

2) Factors supporting knowledge exchange

As identified in the introduction, it is argued that if practitioners and organisations are to deliver on the challenging transformational agenda expected of services, is vital that innovation is evidence-based and supported by effective knowledge exchange (Cooksey, 2006). One hypothesis proposed is that for the implementation to be successful, there needs to be a clear understanding of the nature of evidence being used, the quality of context in terms of its ability to cope with change and type of facilitation needed to ensure a successful change process (Kitson et al 1998). These authors developed the PARIHS (Promoting Action on Research Implementation in Health Services) model as a multifaceted conceptualisation of the three key factors involved (Rycroft-Malone et al, 2002).

The overall aim of this project, to embed outcomes in reablement in North Lanarkshire, remained constant throughout the project. The changes which were to

emerge related to some of the objectives and to the latter stages of the eight stage model of change. The objectives were as follows:

- To build on existing knowledge exchange activity between the researcher and the partner (North Lanarkshire Council) by investigating in detail an issue which is both a local priority and a national policy imperative.
- To establish current practice with regard to outcomes within homecare re-ablement services in North Lanarkshire.
- To explore the applicability of existing evidence about outcomes in a practice setting using a KE process, which will distill key messages from formal research studies, practice wisdom and user/carer perspectives.
- To establish the challenges in the existing approach to outcomes within homecare re-ablement, using a case study approach within two homecare re-ablement services in North Lanarkshire.
- To capture new insights gained from the project and generate guidance and tools to support continuing implementation both locally and nationally, including audio-visual material on embedding outcomes in homecare and re-ablement.

Most of these objectives were achieved, at least to some extent, as evidenced in this report. The key alteration in the project direction, as identified in chapter five, was the move away from the objective to produce a tool and associated guidance in order to embed outcomes. This shift was to effect stages 4 to 7 of the model. Each stage of the model is revisited below, with any key changes to each stage noted in brackets:

Stage 1 will establish key messages from the literature as they relate to outcomes and re-ablement. In addition a small number of strategic staff within the local authority and other providers will be interviewed to establish a baseline for current practice.
[This stage was carried out as planned. The literature review is included in chapter one. The methodology and analysis of the interviews is included in chapter two].

Stage 2 will test out via focus groups the applicability of the key messages identified in stage 1 with practitioners and managers across two re-ablement teams in North Lanarkshire.
[This stage was undertaken and involved two focus groups with reablement teams. There main emphasis was on evidence about personal outcomes and the potential for embedding these in reablement. This stage is reported in chapter three].

Stage 3 will synthesise the messages from research via an Expert Group comprising practitioners, researchers and external advisors including Partnership4Change. Volunteers will also be recruited for digital stories.
[Stage 3 involved convening an expert focus group consisting of people using services, family carers and voluntary sector support workers only. A separate residential retreat involving home support staff, OTs, psychologists and managers was also held. The focus group with people using services and families is reported in chapter three and the residential retreat in chapter four].

Stage 4 will produce detailed guidance on the optimum model of practice, including relevant tools to ensure outcomes are embedded in the re-ablement model in North Lanarkshire

Stage 5 will test guidance and tools through a second focus group to consider any challenges and concerns from the practitioners.

Stage 6 will convene a second Expert Group meeting to finalise the model to be developed. A further output of this event will be detailed guidance for dissemination.

Stage 7 will involve implementation of the model within North Lanarkshire.

[Stages 4, 5, 6 and 7 involved the most significant variation from the original plan. These stages were most closely aligned to the objective of producing a tool and guidance. The shift away from focusing on a tool was influenced by significant local change initiatives happening alongside this project. The changes are discussed in detail in chapter five.]

Stage 8 will focus on dissemination of project outputs across Scotland and beyond via IRISS.

With regard to the first factor identified in PARIHS, the nature of the evidence, the authors suggest that successful implementation is most likely when the evidence matches professional consensus and patient needs (Rycroft-Malone et al, 2002). In the case of embedding outcomes in reablement, established outcomes focused practice in North Lanarkshire offered advantages to this project, in that senior and operational managers already had a strong understanding of outcomes and the concept was easily grasped by home support staff. While the concept of outcomes was not familiar to the focus group with people using services and carers, there was identification with the potential to improve initial engagement and to consider individual circumstances and capacities. The staff groups confirmed the need to improve initial engagement with people being referred to reablement and the ability to monitor both quality of life and change outcomes over time were identified as important. To a large extent then, the case for outcomes had largely been made before the project started.

The focus of the project therefore was less on making the case than on how to make it happen, again as highlighted in the plan. Having said that, the literature review, which was conducted with a focus on factors relevant to embedding outcomes was viewed as helpful in making the case for change, particularly by the service manager.

For this project, it was the second factor of the PARIHS model which had most immediate impact on the project direction, as the context of wider changes happening within North Lanarkshire. It is important to note however that the shift in focus away from developing a tool did not raise undue concern for colleagues in North Lanarkshire, who identified that this objective would be linked to and supported by wider changes in assessment and care management. Nor did it raise significant concern for the researcher, due to previous learning about implementation of an outcomes approach, which demonstrated that the focus needs to be broader than the a tool and requires changes in culture, systems and processes (Cook and Miller 2012). Therefore a significant degree of adaptability was required by both partners, while retaining a focus on the overall aim and potential benefits of the project. As identified in chapter five, the shift away from the narrow focus on the tool enabled a refocus on broader contextual factors which required to be acknowledged and addressed, and which emerged through the various knowledge exchange processes identified in

chapters two to four, and as highlighted in table one. Other contextual factors were supportive, including community capacity building work which was welcomed by both the reablement teams and the second focus group with people using services.

Final very brief consideration will be given to the third factor, the role of facilitation in this knowledge exchange process. This project represented the latest in a number of knowledge exchange episodes between North Lanarkshire Council and the researcher. At the time of writing the project has just been finalized. An approach to checking back with stakeholders as to the impact of facilitation as compared to strength of the evidence is being put in place and will be reported separately in a follow up report.

Conclusion

The literature review at the start of this project was undertaken with a focus on messages pertinent to the project aim to embed outcomes in reablement. Key relevant themes emerged in the literature, including the importance of spending time at the beginning of the intervention getting to know the person, understanding their expectations, motivations and concerns, and working to establish good relationships with staff. This was considered particularly important when individuals have been used to traditional home support, as the shift to supporting independence was subject to misinterpretation, and potential benefits need to be explored on an individual basis. The need to engage effectively with quality of life outcomes and especially social inclusion, was highlighted as a key area requiring attention.

The need to establish a reablement culture rather than distinct teams was reinforced by staff concerns about reversal of reablement goals when individuals return to a mainstream service. It as identified that shifting from the narrow performance lens of hours of home care saved by reablement to a wider range of personal outcomes offers real potential to improve the effectiveness of the service, as well as to demonstrate its full value. The tendency to limit criteria for who is included in reablement when driven by hours of service saved can work against a broader reablement culture and longer term monitoring of outcomes is required to achieve a more balanced picture.

North Lanarkshire has already made significant efforts to develop systems, culture and practice supportive of an outcomes approach in home support. Through engaging with multiple stakeholders, this project has confirmed the significant challenges of achieving this in a service sector, which is well known for resource constraints and associated challenges. Given the commitment to focusing on outcomes, despite the challenges, there is potential to develop a virtuous cycle, whereby outcomes focused plans and reviews will not only help to address quality of life of service users but will also provide the stories and evidence which will in turn help with developing understanding amongst staff, other services and the public about what reablement is. This may also prove essential in making the case for the necessary resources.

Further opportunities are arising from the redesign of the service. The skills and dedication of a section of the workforce who are well supported by the service were in evidence at the retreat. The planned activities to engage the wider workforce will be critical, including increases in capacity, support and training for staff in order to improve service user outcomes, including in the slightly longer term the independent

sector partners too. The psychology capacity building project will help teams in engaging with individuals and families about their quality of life and independence.

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