

A realist synthesis and evaluation of the role and impact of
occupational therapists in reablement services

Lisa CJ Dibsall

A thesis submitted in partial fulfilment of the requirements of the University of
the West of England, Bristol for the degree of Doctor of Philosophy

Faculty of Health and Applied Sciences, University of the West of England, Bristol

January 2019

Abstract

Reablement services aim to improve the ability of people experiencing poor health or disability to complete daily living tasks. This study proposed that occupational therapists have a broad role in reablement working with service users to increase their independence and occupational engagement and promoting the ethos of reablement with members of the team. The role of occupational therapists was evaluated from the perspective of occupational therapists in practice and managers and reablement support workers who work with them.

A realist approach was taken commencing with a realist synthesis review of the literature that identified four programme theories: the recognition of occupational therapists by others; holistic approaches to assessment and goal setting; the provision of equipment; and working with support workers. The programme theories were tested, refined and expanded using a qualitative case study design. Each of the three case studies consisted of a reablement service that comprised two organisations. Methods of the study included observations and interviews with occupational therapists in practice, interviews with managers and focus groups with reablement support workers.

This study contributes to knowledge of occupational therapists in reablement services with the presentation of a conceptual framework for practice. The framework can be used by organisations to consider the different contextual layers of reablement during the design and commissioning of a service. Findings conclude that occupational therapists make a positive contribution to reablement services. Occupational therapists' education and experience underpin their ability to undertake assessments, person centred goal setting and select from their toolbox of interventions to support service users. Occupational therapists' informal and formal training with support workers encourages a reabling ethos. Effective policies, good communication and co-location were identified as factors supporting the two new programme theories identified in the study regarding team working and a shared purpose of reablement.

Acknowledgements

I would like to thank my supervisors Dr Stuart McClean and Dr Ailie Turton for introducing me to new ideas and providing invaluable feedback throughout this thesis. Their unwavering support has enabled me to complete this thesis.

I express grateful thanks to all the participants in my study. Without their contribution this study would not have been possible. I also thank my work colleagues and church friends who have listened to me talk through aspects of my project and willingly read drafts of my chapters.

Finally, I dedicate this thesis to my family. To my parents for their encouragement and interest in my study. To my husband and two boys who despite not understanding my study have given me the space to finish my 'homework'.

Table of contents

Abstract	ii
Acknowledgements.....	iii
Table of contents	iv
Index of Tables	xiv
Index of Figures.....	xiv
Index of Boxes	xv
Index of Vignettes	xv
1 Introduction.....	1
1.1 Background	1
1.2 Definition of reablement	2
1.3 Occupation and occupational therapy	3
1.3.1 Early occupational therapy practice.....	4
1.3.2 Occupational therapists' early days working for the Local Authority .	6
1.3.3 Professionalisation of occupational therapy.....	7
1.3.4 Influence of the disability movement.....	9
1.3.5 Occupational therapists and the social model of disability	10
1.3.6 Growth of research and theoretical models	12
1.3.7 A new focus on personalisation and prevention services	14
1.3.7.1 Prevention	15
1.3.7.2 Person centred practice	17
1.4 Reablement and occupational therapy.....	19
1.4.1 Current reablement provision	22
1.5 Rationale for this study	24
1.5.1 Study aim and research questions.....	25

1.5.2	Outline of thesis	26
1.6	Conclusion	26
2	Methodology and methods – phase 1: identifying realist programme theories	28
2.1	Introduction.....	28
2.2	Philosophical position.....	28
2.2.1	Positivism.....	28
2.2.2	Interpretivism	31
2.2.3	Critical realism.....	32
2.2.4	Philosophical and methodological underpinnings to this study	35
2.3	Realist evaluation.....	35
2.3.1	Mechanisms, contexts and outcomes.....	37
2.3.2	Occupational therapy as a complex intervention.....	38
2.3.3	Critique of Pawson and Tilley’s realist evaluation.....	40
2.4	Methodology.....	41
2.5	Realist synthesis.....	42
2.5.1	Identifying the research question.....	43
2.6	Summary	45
2.6.1	Realist research rather than a realist evaluation.....	45
3	Realist synthesis	47
3.1	Introduction.....	47
3.2	Identifying the review question	48
3.2.1	Contact with experts in the field	48
3.2.2	Outcomes for service users	49
3.2.3	Outcomes for members of the reablement team.....	49
3.3	Stage 2 Searching for primary studies	51

3.3.1	Search terms	51
3.3.2	Databases searched	53
3.3.3	Inclusion criteria.....	54
3.3.4	Exclusion criteria	54
3.4	Results of literature search.....	55
3.5	Stage 3 Quality appraisal.....	58
3.5.1	Relevance	58
3.5.2	Rigour.....	59
3.6	Stage 4 Data extraction	59
3.6.1	If...then propositions	60
3.6.1.1	Outcomes for service users and carers	60
3.6.1.2	Outcomes for reablement team members.....	61
3.6.2	Programme theories	61
3.6.3	Search for articles to confirm or refute the theories developed	73
3.7	Stage 5 Synthesising the data.....	73
3.7.1	Programme theory 1 recognition of the role of occupational therapists.....	74
3.7.1.1	Occupational therapists' views of their role in reablement.....	75
3.7.1.2	The context of complexity	76
3.7.2	Programme theory 2 holistic practice by occupational therapists	77
3.7.2.1	Assessments.....	78
3.7.2.2	Goal setting and reablement plans	79
3.7.3	Programme theory 3 timely provision of equipment	81
3.7.3.1	Positive outcomes from the provision of equipment and adaptations	82
3.7.3.2	Timeliness of provision of equipment	83
3.7.3.3	Acceptability.....	85

3.7.4	Programme theory 4 occupational therapists and support workers	.86
3.7.4.1	The role of support workers	.....86
3.7.4.2	Formal training of support workers	.....88
3.7.4.3	Informal support	.....89
3.8	Conclusion	.....90
3.8.1.1	Reflection on the realist synthesis approach	.....91
4	Methodology and methods – phase 2: testing the programme theories	.....9
2		
4.1	Introduction	.....92
4.2	Qualitative approach	.....92
4.2.1	Qualitative research in occupational therapy	.....93
4.3	Choosing a qualitative methodology	.....93
4.3.1	Case study methodology	.....95
4.4	Quality in qualitative research	.....96
4.4.1	Reflexivity	.....98
4.5	Selecting case studies	.....101
4.5.1	Recruitment of case studies	.....102
4.5.2	Description of the case studies	.....102
4.6	Ethics	.....103
4.6.1	Permission from each case study area	.....103
4.6.2	Main ethical issues	.....104
4.6.2.1	Risk of coercion	.....104
4.6.2.2	Visiting service users and carers at home	.....105
4.6.2.3	Emotional impact of being interviewed	.....105
4.6.2.4	Confidentiality of data	.....106
4.7	Recruitment of individual participants	.....107

4.7.1	Occupational therapists and managers of the Service	107
4.7.1.1	Support workers.....	107
4.7.1.2	Service users	108
4.8	Participants in the study	110
4.9	Data collection.....	111
4.9.1	Observations and documentation	111
4.9.1.1	Observations undertaken	112
4.9.2	Reflection on observations note taking.....	112
4.9.3	Interviews.....	113
4.9.4	Focus groups	115
4.9.5	Member checking.....	116
4.10	Data analysis	117
4.10.1	Relying on theoretical propositions.....	118
4.10.2	Explanation building	118
4.10.2.1	Steps of data analysis	119
4.11	Profiles of the case studies	122
4.12	Tollbury profile	122
4.12.1	Demographics of the area	122
4.12.2	Structure of the service	123
4.12.3	Remit of the service	126
4.12.4	Eligibility for reablement	126
4.12.5	Records.....	127
4.12.6	The pathway following reablement	127
4.13	Foybrook profile	127
4.13.1	Demographics of the area	127
4.13.2	Structure of the service	127
4.13.3	Remit of the service	128

4.13.4	Eligibility for reablement	B0
4.13.5	Records.....	B1
4.13.6	The pathway following reablement	B1
4.14	Averdale profile.....	B1
4.14.1	Demographics of the area	B1
4.14.2	Structure of the service	B1
4.14.3	Remit of the service	B4
4.14.4	Eligibility for reablement	B5
4.14.5	Records.....	B5
4.14.6	The pathway following reablement	B5
4.15	Summary	B6
5	Findings.....	B7
5.1	Presentation of findings	B7
5.2	Programme theory 1 – recognition of the role of occupational therapists	B9
5.2.1	Right person, right time’	141
5.2.2	Seeking recommendations to support practice	142
5.2.3	Doubled handed care	143
5.2.4	Occupational therapy involvement in the development of reablement services	146
5.3	Programme theory 2 – holistic and person centred practice	146
5.3.1	Working with the ‘whole person’ – being person centred	147
5.3.2	Assessment.....	149
5.3.2.1	Approaches to assessment.....	150
5.3.2.2	Occupational Performance assessment	150
5.3.2.3	Standardised assessments.....	151
5.3.3	Goal setting.....	153

5.3.3.1	Setting person centred goals – a learned skill	154
5.3.3.2	‘No person is an island’	155
5.3.3.3	Mechanism of safety	156
5.3.3.4	Establishing rapport and gaining trust	157
5.3.3.5	Realistic goals	158
5.3.4	Influence of team policy/manager perspective	159
5.4	Programme theory 3 – using a toolbox of interventions	161
5.4.1	Occupational therapists as respected members of the team	161
5.4.2	Analysing difficulties	163
5.4.3	The knowledge bank and the occupational therapy tool box	164
5.4.3.1	Information and advice.....	164
5.4.4	(Re)establishing routines	165
5.4.5	Provision of equipment	167
5.4.5.1	Range of equipment available	168
5.4.5.2	Equipment was not always successful.....	170
5.4.5.3	View of equipment by service users	170
5.4.6	Considering the needs of carers.....	172
5.5	Programme theory 4 – occupational therapists and support workers	173
5.5.1	Trust in ability of support workers to reable	175
5.5.2	Training support workers.....	176
5.5.2.1	Support workers, service users and equipment.....	177
5.5.3	Changes in training of support workers	179
5.6	New programme theories identified.....	180
5.7	Programme theory 5 – working as a team.....	181
5.7.1	Knowing your colleagues - working face to face.....	183
5.7.2	Communication and trust.....	184
5.7.3	Feedback on service user progress.....	186

5.7.4	Disagreements between reablement team members	188
5.8	Programme theory 6 - shared purpose and 'buy in' to reablement	189
5.8.1	Occupational therapy philosophy and reablement	192
5.8.2	Support workers 'buy in' to reablement	193
5.8.3	'Buy in' by service users	195
5.8.4	'Six weeks free'	196
5.8.5	Service user motivation	196
5.8.6	'Buy in' at the organisation level	197
5.8.6.1	The impact of legislation	197
5.8.6.2	Who can be supported by reablement?	198
5.8.6.3	The integrated health and social care team	198
5.8.7	Right service, right time?	199
5.9	Summary	202
6	Discussion	204
6.1	Introduction	204
6.2	Development of a conceptual framework	204
6.3	Occupational therapy philosophy and the shared purpose of reablement	208
6.3.1	A clear role for occupational therapists in reablement	208
6.4	Holistic and person centred practice	210
6.4.1	Therapeutic use of self	214
6.4.2	Presentation of therapeutic self	215
6.4.3	Assessment	216
6.4.3.1	Standardised Assessments	217
6.4.3.2	Moving and handling assessments	218
6.4.3.3	Occupational therapists' values and the safety override	219
6.4.4	Goals for reablement	221

6.4.4.1	Clinical reasoning in analysis of situations and decisions for intervention.....	225
6.4.5	Toolbox of occupational therapy interventions.....	227
6.4.5.1	Providing equipment in reablement.....	230
6.5	Occupational Therapists' role as team members.....	231
6.5.1	Shared purpose of reablement.....	232
6.5.2	Working as one reablement service: co-location and communication.....	232
6.5.3	Shared purpose and theories of effective teams.....	234
6.5.3.1	Service users' 'buy in' to the ethos of reablement.....	236
6.5.3.2	Legislation and Policy.....	238
6.5.3.3	The impact of occupational therapists working with support workers.....	239
6.5.4	Building trust between reablement team members.....	242
6.5.5	The impact of external pressures on the reablement service, 'right service, right time'.....	247
6.6	Summary.....	249
7	Conclusion.....	251
7.1	Introduction.....	251
7.2	Research summary.....	251
7.3	Study aim and research questions.....	252
7.4	Critical reflections on using a realist approach.....	253
7.5	Reflection on being a practitioner researcher.....	256
7.6	What this study adds to the literature.....	257
7.7	Limitations of this study.....	258
7.8	Recommendations for future research.....	260
7.9	Recommendations for practice.....	262

7.10 Closing statement.....	264
References.....	265
Appendices.....	299
Appendix A - Email to social services network of the Royal College of Occupational Therapists.....	299
Appendix B Databases searched in literature review	301
Appendix C Example database search strategy	302
Appendix D Hits obtained from each database.....	303
Appendix E – Appraisal form.....	304
Appendix F Search terms used in second literature search	306
Appendix G Table of use of articles.....	307
Appendix H Social Care Research Ethic Committee Decision Letter	312
Appendix I Social Care Research Ethics Committee Approval Letter	320
Appendix J Interview schedules	323
Appendix K Support worker focus group schedule/topics	327
Appendix L Excerpts from interviews and observation notes	329
Appendix M Examples of data analysis.....	334
Appendix N Excerpt from excel spreadsheet of context mechanism outcome configurations	346

Index of Tables

Table 1 Summary of features of theoretical models	13
Table 2 Stages of the realist synthesis	43
Table 3 Five stages of the realist synthesis	48
Table 4 Screening inclusion criteria	56
Table 5 Evaluation of articles to identify theory	63
Table 6 Participants in the study	109
Table 7 Layers of conceptual framework.....	205
Table 8 Occupational therapy interventions: a pproaches	229

Index of Figures

Figure 1 Generative causation with context, mechanism, outcome configurations	37
Figure 2 A pictorial representation of the intervention and outcome for service users.....	49
Figure 3 A pictorial representation of the programme and outcomes for support workers	49
Figure 4 Flowchart of literature search	57
Figure 5 Services in the Tollbury community	125
Figure 6 Services in the Foybrook community	129
Figure 7 Services in the Averdale community.....	133
Figure 8 CMO configurations - recognition of occupational therapists.....	140
Figure 9 CMO configurations - holistic and person centred practice	148
Figure 10 CMO configurations - toolbox of interventions	162
Figure 11 CMO configurations - occupational therapists and support workers ...	174
Figure 12 CMO configurations - working as a team.....	182
Figure 13 CMO configurations - shared purpose.....	191
Figure 14 Conceptual framework of occupational therapists in reablement services	206
Figure 15 Proposed Model of Trust	243

Index of Boxes

Box 1 Programme theory one - recognition of occupational therapists.....	74
Box 2 Programme theory two - holistic practice.....	77
Box 3 Programme theory three - timely provision of equipment	81
Box 4 Programme theory four - occupational therapists and support workers	86
Box 5 CMO configurations and programme theories.....	138
Box 6 New Programme Theories	139
Box 7 Programme theory one - recognition of occupational therapists.....	139
Box 8 Programme theory two - holistic and person centred practice	147
Box 9 Programme theory three - provision of equipment	161
Box 10 Programme theory four - occupational therapists and support workers ..	173
Box 11 Programme theory five - working as a team.....	181
Box 12 Programme theory six - shared purpose and 'buy in' to reablement	190

Index of Vignettes

Vignette 1 A reduction in support required for Connie.....	145
Vignette 2 Setting goals with Esther	159
Vignette 3 Supporting Donna to manage her meals.....	166
Vignette 4 Supporting Dorothy with a cleaning routine.....	166
Vignette 5 Confidence in support workers.....	176
Vignette 6 Teams in the community supporting Catherine	201

1 Introduction

1.1 Background

The purpose of reablement is to support people experiencing poor health or disability to undertake daily living tasks for themselves. Those daily living tasks for occupational therapists are called occupations. Enabling people to engage in their chosen occupations is the core purpose of occupational therapy. There is no blueprint for the development of reablement services or the configuration of staff in the reablement team. Consequently, occupational therapists play a greater or lesser part in current reablement services. Current research on reablement has focussed on reablement as a whole, with some references to occupational therapists, primarily as providers of equipment and adaptations (Jones, Baxter, Curtis *et al.*, 2009; Littlechild, Bowl and Matka, 2010; McLeod and Mair, 2009). Professional bodies have asserted the role of occupational therapists in reablement teams (College of Occupational Therapists, 2010; Social Care Institute For Excellence, 2011b). A limited number of studies have focussed on the effectiveness of occupational therapists in reablement from a quantitative perspective (Latif, 2011; Whitehead, Walker, Parry *et al.*, 2016). This thesis provides an important contribution to research on the current role of occupational therapists in reablement services from the perspective of occupational therapists and members of the reablement service. This thesis demonstrates the contribution that occupational therapists can make to reablement services both for service users and for support workers in the reablement team. Following the background literature to the this study, this chapter concludes with the rationale and research questions for this study

This chapter provides context to the research study in the two pertinent areas of occupational therapy and reablement. It tracks the use of occupation in health care from early times to the emphasis on prevention and reablement services in current legislation. The history of the development of occupational therapy is explored, alongside pertinent legislation that has shaped the progress of the welfare state. This includes the professionalisation of occupational therapy and the development of theoretical models of occupational therapy. The initiation, growth and role of

occupational therapists in Local Authority social care departments will be particularly considered, including the influence of the Disability Living Movement and occupational therapist's move towards a social model of disability. This context illustrates the influences on the profession that have led to the current practice of occupational therapists in social care settings and demonstrates their suitability to work in reablement services.

This chapter will consider both the use of the word reablement, particularly within occupational therapy literature, and the development of reablement services in the United Kingdom (UK). The literature in this chapter is restricted to the history of the welfare state and occupational therapy in Great Britain, with a particular focus on legislation in England, as the location of the research. The provision of health and social care in Northern Ireland is markedly different from the rest of the United Kingdom and therefore will not be included.

1.2 Definition of reablement

There are numerous descriptions and definitions of reablement (Office For Public Management, 2010). Reablement is a time limited service, based on the goals of the person with an aim of increasing independence and reducing the need for ongoing support (Office For Public Management, 2010). This study will use the definition of reablement services, utilised widely elsewhere and adopted by the Royal College of Occupational Therapists¹ (College of Occupational Therapists, 2010; Rabiee, Glendinning, Arksey *et al.*, 2009; Social Care Institute For Excellence, 2010):

‘Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living’

(Care Services Efficiency Delivery, 2007, p.8)

¹ In 2017 the College of Occupational Therapists became the Royal College of Occupational Therapists. Publications before 2017 are cited as College of Occupational Therapists, the college is referred to as the Royal College of Occupational Therapists throughout, regardless of the date.

1.3 Occupation and occupational therapy

The core of occupational therapy practice is the understanding of the importance of engaging in occupation as essential for health and wellbeing. This is epitomised in the often-cited quote from an early occupational therapist Mary Reilly:

'that man, through the use of his hands as they are energised by mind and will, can influence the state of his own health' (Reilly, 1962, p.2)

The dictionary definition of occupation includes occupation both as a job or profession; and as a way of spending time (Oxford University Press, 2017). Occupation in occupational therapy primarily concerns the latter definition. The current definition of occupational therapy adopted by the Royal College of Occupational Therapists in the UK states:

'Occupational therapy enables people to achieve health, wellbeing and life satisfaction through participation in occupation'.

(World Federation of Occupational Therapists, 2017, p.66)

The title of occupational therapist is a protected title by law. All occupational therapists in the UK are required to be registered with the Health and Care Professions Council. The Health and Care Professions Council describe occupational therapists as follows:

'An occupational therapist uses specific activities to limit the effects of disability and promote independence in all aspects of daily life'

(Health and Care Professions Council, 2013a)

Within occupational therapy there has an ongoing debate on the definitions, and use, of terminology of the profession. At the beginning of this century the European Network of Occupational Therapy in Higher Education (ENOTHE) engaged in a terminology project. Six countries across Europe were represented in the project and the agreed European definitions of terminology for occupational therapy were published in the language of the countries represented. For this study the definition of occupation developed from the ENOTHE project group will be used. It defines occupation as:

'A group of activities that has personal and sociocultural meaning, is named within a culture and supports participation in society. Occupations can be categorised as self care, productivity and/or leisure'
(Creek, 2010, p.25)

Occupation has been used in health care through the ages from the encouragement of physical activity in classical times to the emphasis on engaging in labour, as part of the monastic influence on health care, in medieval times (Wilcock, 2001). In these eras a range of people, including philosophers, physicians, monks, nuns, industrialists, lay practitioners, attendants and nurses, prescribed and enabled people to engage in occupations to support health needs. Equipment was designed for people with disabilities by entrepreneurs as early as the late eighteenth century. Equipment was exhibited in museums and invitations were distributed for people to view and purchase equipment for the 'infirm'. In those times people supported themselves with their own health and it is this concept of enabling people to help themselves that is key to occupational therapy practice now (Wilcock, 2001).

1.3.1 Early occupational therapy practice

Occupational therapy was first established in Britain in 1919, having commenced formally in the United States of America with the founding of the National Society for the Promotion of Occupational Therapy in 1917 (Wilcock, 2002). At that time occupational therapy had a close association with the medical profession who directed their practice. Occupational therapy, in line with other 'non-medical' staff groups, was seen to not have a clear theory base of its own (Creek, 2010). This continued into the 1960s and is confirmed in a manual written for occupational therapists on physical rehabilitation. The section on the referral of patients to occupational therapy states that the referral should come from the patient's doctor and that:

'it is part of her [the occupational therapist] ethical code to treat only on medical 'prescription'' (MacDonald, 1964, p.16)

Early practice of occupational therapy concentrated on working with people with psychiatric conditions using graded activity to either improve 'nervous disorders' or as a diversion technique, using arts and crafts activities (Anthony, 2005).

Following the First World War and during, and following, the Second World War occupational therapy was focussed on the rehabilitation of service personnel to enable them to return to work.

There have been many attempts to define rehabilitation without consensus (Meyer, Gutenbrunner, Bickenbach *et al.*, 2011). The World Health Organisation's most recent definition of rehabilitation states:

'a set of measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environments'

(World Health Organization and World Bank, 2011)

This definition of rehabilitation focuses on the functional ability of the person and is evident as the aim of practice throughout the history of occupational therapy. Activities used by occupational therapists for the rehabilitation of service personnel during wartime included using adapted machinery, such as printing presses and saws that were operated using legs rather than arms and hands. The equipment was adapted to support physical function such as increasing muscle strength or range of movement, alongside teaching patients new skills that would support them to earn a living (Wilcock, 2002). The focus on supporting people to return to work following illness was further advocated in later textbooks, alongside supporting people with permanent disabilities to increase their independence in daily living activities (MacDonald, 1964).

Hocking (2008a) discusses the association of occupational therapy with the Arts and Craft Movement in her historical analysis of the development of occupational therapy in the UK. Hocking's analysis of early occupational therapy literature established that occupational therapists were using craft activities with people in psychiatric settings with the assumption that producing high quality creative items would be motivating to patients, and have therapeutic benefit. Hocking tracks a move away from this practice to occupational therapists justifying their practice through linking practice to theory and working with people on daily living skills (Hocking, 2008c). Occupational therapists focussed on increasing

their knowledge and skills in the use of activities for therapeutic purposes, for example, cord knotting for strengthening weak hands (Hocking, 2007).

Moving away from the use of craft activities and adapted machinery and tools, a British occupational therapist, Grizel MacCaul, promoted the use of activities of daily living to improve functional ability suggesting, for example, that the activity of dressing would work on a person's weak grip and a stiff shoulder as much as weaving would (Hocking, 2008b). It was at this time that the development of assistive devices expanded. Hocking (2008c) provides a useful table of assistive devices and their function based on literature from the 1950s and 1960s including devices to support self-care such as adapted clothing, cutlery with large handles to support grip and hoists to move people in bed. The table also includes devices to support domestic activities, such as a wooden long lever to aid using taps and a trolley to carry items and provide support for mobility. The difficulties evident in the patients of the time such as inability to move in bed or having use of only one arm or difficulties with grip are still relevant today. Assistive devices, also known as disability equipment, is provided by occupational therapists for these difficulties, and many others, throughout health and social care settings.

1.3.2 Occupational therapists' early days working for the Local Authority

Occupational therapy from 1919 was primarily undertaken in hospital settings as providers of health care. This continued following The National Health Service Act 1946 (9 & 10 Geo. 6, Ch.81) that saw the birth of the National Health Service (NHS) in 1948, and a subsequent demand for occupational therapists to work in the new NHS (Wilcock, 2002).

Provision of social care originated in the Poor Law 1601 (43 Eliz. I, Ch.2) that was based on relief of the destitute. Parishes provided alms houses and passed on small amounts of money to the 'impotent poor', including the elderly and blind. The Amendment to the Act in 1834 saw the development of workhouses in each parish. The Poor Law 1601 was superseded by the National Assistance Act 1948 (11 & 12 Geo. 6, Ch.29) that saw the end of workhouses and gave Local Authorities the duty to provide suitable accommodation for those in need due to age or infirmity. The Act also gave Local Authorities the power to promote the welfare of people with

physical disabilities, including giving people in their own homes 'instruction' to overcome the effects of their disabilities and providing recreational facilities and workshops to engage people in work activities. Occupational therapists began to visit people with disabilities in their own homes both to increase independence through the modification of household tools and the environment and to deliver 'work at home' items (Wilcock, 2002). The 'instruction' nature of these powers reflect the medical model of overcoming difficulties, and the prescription of occupational therapy by doctors, as previously described.

The word 'instruction' also suggests a power relationship between the Local Authority and people with disabilities. Clark (2010) suggests that having power is not inherently good or bad. She suggests that powerful occupational therapists can influence authorities to provide, for example, resources to meet the needs of the service users they are working with. Following early occupational therapy provided under the direction of the medical profession, Hocking's analysis of occupational therapy literature from 1938 – 1951 suggests that during this time occupational therapists were seeking a theory base for occupational therapy. The British occupational therapy journal of the time published requests for research into occupational therapy from 1944 (Hocking, 2007). This evidence suggests that occupational therapists were seeking legitimacy as an individual profession; distancing themselves from the medical profession, to exert more influence and power in the different settings in which they practiced.

1.3.3 Professionalisation of occupational therapy

Reablement teams consist of a range of health and social care professionals and trained staff. This section considers sociological approaches to professions and the unique contribution of the occupational therapists.

The nature of 'profession', 'professionalisation' and 'professionalism' are contested concepts. Brante (1988) presents two sociological approaches to professions: functionalist and neo-Weberian. From a functionalist perspective, Parsons (1939) asserts that professions are important in society as pursuers of 'technical competence' in a particular field. Professions have characteristics of theoretical knowledge, education and competence, a code of conduct and organisation of

members by a professional body. The self-regulating group works for the 'common good' whilst also wielding an element of power in society (Brante, 1988). There is evidence that occupational therapy characterises professions in this way. The first school of occupational therapy in the United Kingdom opened in 1930 with the Association of Occupational Therapists initiated in 1936. The first Code of Practice for occupational therapists followed in 1943 and the first statutory registration as a profession allied to medicine began in 1957 (Wallis, 1987).

Brante's (1988) discussion on the neo-Weberian approach describes closure theory as an alternative wielding of power in that professions use their exclusive knowledge to exclude others and further their own interests. Freidson (1986) firmly ascribes professions to the demand of the labour market. He coins the term 'market shelters', asserting that professions are occupations with higher education training that serve as prerequisites for certain jobs in the labour market. Clouston and Whitcombe (2008) discuss the professionalisation of occupational therapy and suggest that occupational therapists' central concept of occupation is not exclusive to occupational therapy but stems from an evidence base from the medical profession. Hocking and Nicholson (2007) discuss the use of the word occupation in the International Classification of Functioning, Disability and Health (ICF) (World Health Organization, 2001). They assert that the consideration of occupation in other professions:

'makes a better physiotherapist, nurse, doctor, gerontologist, speech and language therapist, counsellor or community developer'

(Hocking and Nicholson, 2007, p.47)

They conclude that the unique aspect for occupational therapists is recognising the value of occupation for service users (Hocking and Nicholson, 2007). Understanding occupation is a prerequisite for obtaining a qualification as an occupational therapist as it is included in pre-registration training (College of Occupational Therapists, 2014). Focus on the theoretical basis of occupational therapists and the power this might wield for occupational therapy as a profession needs to be considered alongside the influence of the disability movement.

1.3.4 Influence of the disability movement

Reablement is predominantly a service commissioned by social care departments of Local Authorities. As previously described, occupational therapists were initially located in hospitals under the influence of the medical profession and the associated medical model of disability. This section illustrates the influence of the Disability Movement and the social model of disability on occupational therapists working in social care in the community.

The disability movement originated in the USA and sought for the rights of disabled people to have meaningful roles in society. The Disability Movement rejected the idea of the medical model of disability in which the focus is on curing the condition or impairment (Craddock, 1996a). In the UK, the Disabled People's International was formed and they developed the Union of the Physically Impaired Against Segregation. It was this latter group that published their own model of disability based on impairment and disability, which became known as the social model of disability (Masala and Petretto, 2008). In their model, people are considered as disabled not by their bodies but by society. The 'defective' part of the body is seen as an impairment and disability as the restriction to being able to perform an activity, due to social environments and contexts designed for the 'able-bodied'.

The Disabled Living Movement in the UK was formed in 1963. The movement developed an information service for the disabled, described as a central resource for people with disabilities, occupational therapists and others. The Disabled Living Foundation was founded in 1969 and set up centres, staffed by occupational therapists, with equipment for people with disabilities, (Wilcock, 2002). Craddock (1996b) reviewed occupational therapy literature published in the UK from 1989 to 1994 and found very few references to the impact of the disability living movement on occupational therapy practice. Craddock printed an early definition of occupational therapy by the World Federation of Occupational Therapists in 1989:

'The treatment of physical and psychiatric conditions through specific selected activities in order to help people to reach their maximum level of function in all aspects of daily life' (Craddock, 1996b, p.21)

This definition continues the focus on treatment and illustrates the continued influence of the medical profession on occupational therapy and the key legislation of the time, the National Assistance Act 1948, as previously described.

1.3.5 Occupational therapists and the social model of disability

Legislation subsequent to the National Assistance Act 1948 emphasised adapting environments to promote independence. This can be considered as a step away from the medical model to the social model of disability. Decisions made concerning the employment of occupational therapists in the NHS Reorganisation Act 1973 Clause 18(4)(b) (HM Stationery Office, 1973) began the division of occupational therapists into the fields of health or social care. This Act called for the transfer of relevant staff from Local Authorities who administered 'personal health services' in the community, into the new Health Authorities. Unlike other staff, occupational therapists were already established in both hospital and community settings. Therefore it was proposed that occupational therapists working under medical supervision with people receiving medical treatment would transfer to the health authority. Occupational therapists providing social rehabilitation for people who were not under medical supervision remained with the Local Authority. At that time the Association of Occupational Therapists asserted their stance, still echoed today, that it was difficult to separate health and social care support (Wilcock, 2002).

Two Acts in 1970, the Local Authority Social Services Act 1970. Ch 42 and the Chronically Sick and Disabled Person's Act (Department of Health and Social Security, 1970) saw occupational therapists working in the newly formed social services departments. The year after social services departments were formed 71% of departments employed occupational therapists (Wilcock, 2002). Their role involved the provision of equipment and adaptations; as Local Authorities used occupational therapists to meet their statutory duty to assess needs and provide services to those considered to be in need of their services. A letter to *Occupational Therapy* (the journal of the Association of Occupational Therapists) in 1973 by three occupational therapists working in social services, confirmed their role in providing equipment to enable people to remain independent and prevent unnecessary admissions to hospitals and care homes (Rees, Bourne and Whittington, 1973). This

statement, and a second one on the importance of working with home helps and other members of the social services team on a rehabilitation plan for people when they return home from hospital, are mirrored in the aims and objectives of reablement services today.

The importance of enabling people to return home was taken on by the occupational therapy community. In 1977 the first European Congress was opened with a session by the Parliamentary Under Secretary for State for Scotland, Harry Ewing, who outlined the government's aim for the 'chronically sick, geriatric and disabled people' to be integrated into the community by creating a barrier free environment. Mr Ewing highlighted the 'vital role' that occupational therapists played in meeting this aim (Wilcock, 2002). The Housing Act 1974. Ch. 44 had provided legislation for the adaptation of homes by Local Authorities for people with disabilities, to provide for example, ramps and food preparation areas at a suitable height. The role of occupational therapists in social care departments was to assess the need for adaptations to someone's home. This represents a move away from treatment, in the medical sense, and focuses on removing environmental barriers for the person (Craddock, 1996a). A County Council building surveyor of the time asserted the benefit of architects, surveyors and occupational therapists working together with the disabled occupant to use each other's experience (Wilcock, 2002).

The Housing Grants, Construction and Regeneration Act, Ch. 53 heralded further links with housing departments. This Act introduced Disabled Facilities Grants, providing people with a permanent disability an entitlement to apply for funding for major adaptation works to their home including stair lifts, wet room showers and accessible kitchens. The grant is administered by the Housing Authority. There is a joint approach as the Housing Authority must consult with the social services authority to determine whether proposed works are 'necessary and appropriate' whilst the housing authority determine whether the works are 'reasonable and practicable'.

In 1990 The NHS and Community Care Act (Department of Health, 1990) provided a further shift in practice, placing a duty on Local Authorities to undertake needs-led assessments and provide written care plans. The Local Authority became a

purchaser rather than a provider of services. By this time the number of occupational therapists working in the community for the Local Authority had grown tenfold, from approx. 200 in the early 1970s to 2000 full time equivalent posts in 1990 (Richards, 1992). Following introduction of the Act, Abberley (1995) conducted interviews with 16 occupational therapists who had been in practice between one and thirty nine years. Meeting goals was identified as a criteria for measuring success. Goals were identified either by the therapist or jointly agreed with the service user. Goal setting was raised as an important feature with occupational therapists in reablement services in this study. The occupational therapists also highlighted failures in the service due to restricted finances and waiting lists for adaptations. Occupational therapists had to seek financial approval to order equipment for service users. In this way the occupational therapist sought to work under the social model of disability, altering the environment to support the service user. Although they were then, as now, restricted by the context of the organisation declining provision for financial reasons. Assessment of the environment alongside the abilities of the service user and an analysis of the occupation being undertaken were being highlighted in theoretical models of occupational therapy.

1.3.6 Growth of research and theoretical models

The 1980s saw the first publication of theoretical models for occupational therapy in the United States of America and Canada including, amongst others, the Model of Human Occupation, the Canadian Model of Occupational Performance and the Person-Environment-Occupation-Engagement Model (Canadian Association of Occupational Therapists, 1997; Christiansen, Baum and Bass, 2015; Kielhofner, 2002).

The similarities between these models are the focus on three aspects: the person, the occupation and the environment. Table 1 provides a summary of the features of each model. The three models all include the central aspect of occupational therapy: occupation; alongside the needs and abilities of the person and the opportunities and challenges of the environment. Considering the abilities of the

Table 1 Summary of features of theoretical models

Model	Focus of elements of the Model			Unique aspects of the model
	Components of the Person	Occupation	Environment	
The Model of Human Occupation (Kielhofner, 2002)	Volition – motivation to participate in an activity Habituation – habits and roles Performance – physical and cognitive abilities	Activities of daily living Work Leisure Occupations require skills and performance	Resources Opportunities Constraints	Numerous assessments developed to support assessment of different elements of the model
Canadian Model of Occupational Performance (Canadian Association of Occupational Therapists, 1997)	Physical Cognitive Affective	Self care Productivity Leisure	Physical Institutional Cultural Social	At the core of the person is spirituality; the meaning towards an occupation.
Person-Environment-Occupation-Performance Model (Christiansen, Baum and Bass, 2015)	Cognition Psychological Physiological Sensory Motor Spirituality	Activities Tasks Roles	Physical Cultural, Social Social Support and Social Capital Education and Policy Assistive Technology	The first stage of the model focusses on the narrative of the person including their meaning, interests and goals of the person.

person, the occupation they wish to undertake and environmental constraints and resources are all important for working on the goals of a person seeking to undertake a variety of occupations in daily life; essentially learning or relearning skills for daily living as expressed in the definition of reablement.

With the growth in the development of occupational therapy theories in other countries, Mayers (1993) set out to develop a theoretical model for the UK. She developed a Lifestyle Questionnaire for people to complete prior to a community occupational therapist visiting them. In her report of a pilot study with 60 service users, the majority (93%) of service users had been referred to occupational therapy for an assessment of daily living skills and equipment for the bath. Despite this, service users highlighted their priorities as wanting assistance in keeping a clean home and having social contact. Mayer's (1993) pilot study demonstrates how referrers to occupational therapists focussed on personal care activities rather than wider daily living activities and roles. Occupational therapists in the study asserted that information from the questionnaire aided their understanding of the needs of the person and completion of the questionnaire supporting service users' understanding of the role of the occupational therapists (Mayers, 1993).

At a similar time in the UK Professor Averil Stewart discussed the terms empowerment, supporting individuals to take control of their own lives, and enablement, supporting people to achieve their own goals. Stewart asserted that enablement is the focus of occupational therapy enabling people to engage in daily living occupations to influence their own health (Stewart, 1994). The ethos of occupational therapy was leading the way for future reablement services.

1.3.7 A new focus on personalisation and prevention services

Since the development of formal health and social care services the focus has primarily been on supporting those with the highest needs. In the past, this has led to those with lower needs not receiving support until they were in a situation of crisis and would be eligible for statutory services (Allen and Glasby, 2010). There is growing recognition for the need for preventative services for older people.

Government guidance, published in the first decade of the 21st century, called for a focus on the personalisation of services and the development of preventative and

reablement services within social care (Department of Health, 2007; Department of Health, 2009; Department of Health, 2010c). Personalisation is described as:

‘recognising people as individuals who have strengths and preferences and putting them at the centre of their own care and support.’

(Social Care Institute for Excellence, 2012, p.2)

The concordat ‘Putting People First’ (Department of Health, 2007) valued the well-being of older people and people with chronic conditions, disabilities or mental health problems and stated the commitment that this group would have the best quality of life and independent living. The concordat set out aims for a transformation of social care, through personalisation. It called for a move away from reactive care to supporting independence through reablement and prevention interventions, focussing on service users’ outcomes and person centred support.

Occupational therapists have linked personalisation to being holistic and person centred. Six occupational therapists in the qualitative study by London-Willis, Couldrick and Lovelock (2012) described occupational therapists as holistic and person centred and therefore asserted that personalisation would have little impact on their work. Despite this, the congruence between providing choice with the personalisation of services, whilst working within budgetary constraints was highlighted. Occupational therapists in the study concluded that personalisation is an opportunity for occupational therapy if it is accompanied by an increased awareness of social care. One occupational therapist went further, asserted that personalisation itself would increase the awareness of a need for occupational therapists within social care (London-Willis, Couldrick and Lovelock, 2012)

1.3.7.1 Prevention

A National Expert panel of leading academics, policy makers, clinicians and voluntary organisations sought to construct and validate a model of care for older people. The panel’s report on preventative services highlighted the lack of clarity regarding the definition and method for undertaking preventative services; and expressed concern about the feasibility of embedding preventative services into mainstream services. The panel asserted that reablement services required a

change in culture from focusing on services to evaluating outcomes. They recognised that this requires training for support staff (Allen and Glasby, 2010).

At the same time The Partnerships for Older People Projects Programme sought to define prevention and identified four elements for prevention:

1. *Delay or reverse older people's deterioration*
2. *Reduce the risk of crises and the harm arising from them*
3. *Maximise people's functioning*
4. *Provide care 'closer to home'*

(Department of Health Social Care Policy and Innovation, 2010, p.6)

Reablement was included as an example of a service maximising people's function. The report asserted that 'well-optimised' care services emphasise prevention including reablement. The report describes the current financial state of care and suggests that investing in preventative services is cost efficient for health and social care services (Department of Health Social Care Policy and Innovation, 2010)

The Care Act (Department of Health, 2014) has been described as the biggest change to social care since the Chronically Sick and Disabled Person's Act, 1970 (Department of Health and Social Security, 1970), which it repeals. The Care Act repeals a significant amount of previous legislation including the National Assistance Act and the NHS and Community Care Act 1990. The Care Act 2014 places a duty on Local Authorities to promote well-being. There are specific duties to provide prevention services ranging from primary prevention, such as leisure facilities and accessible transport available to everyone in the community, to individual prevention services. The Care Act 2014 promotes reablement services and the provision of equipment and adaptations to support people to be independent and prevent people requiring admission to hospital or ongoing support. For occupational therapy the Care Act 2014 reinforces the importance of wellbeing and quality of life as described in the definition of occupational therapy. The Care Act statutory guidance (Department of Health, 2017) names occupational therapists as key in assessing the needs of service users and as one of the professionals that would work in a person centred way to support effective prevention services.

1.3.7.2 Person centred practice

This study uses the term person centred practice in line with the terminology of legislation supporting reablement, namely the Care Act, 2014. The terms person centred practice, patient centred practice and client centred practice can be used interchangeably as the terms client, patient or person reflects the changing terminology for people who have contact with health and social care services.

It is worth pausing to consider the terms used for the people that occupational therapists work with in health and social care. The term patient is frequently used in health settings and reflects the medical model with the definition of a patient as 'a person receiving or registered to receive medical treatment' (Oxford University Press, 2018). Terms for a person involved with social care services are more varied and include client, consumer, customer, service user and expert by experience (Fawcett, Fillingham, River *et al.*, 2018; Hübner, 2014; McLaughlin, 2009). Changes in terminology have been influenced by political changes (Hübner, 2014). Use of the word client, frequently used in the 1970s, has been challenged as a term suggesting a power imbalance with professionals identifying needs of passive clients (Fawcett, Fillingham, River *et al.*, 2018; McLaughlin, 2009). Following the election of the conservative government in 1979 Local Authorities became purchasers rather than providers of services, as previously described. Users of social care services were seen as customers able to choose from a range of providers (McLaughlin, 2009).

A review of social work publications concluded that service user was the most frequently used term (Hübner, 2014). During this research the words patient, service user, customer and client were all used to describe the person participants worked with. I considered using the term person and people and discounted this as I was keen to distinguish between the person the participants were working with and other people such as carers and family members. I opted to use the single term service user for all references to people that participants in this study worked with, for ease of the reader and as this is the preferred term in publications for occupational therapists by the Royal College of Occupational Therapists (see College of Occupational Therapists, 2015a; Royal College of Occupational

Therapists, 2017). When referring to other sources the original terminology is maintained, as evidenced in the following paragraphs.

The definition of client centred practice for occupational therapists, produced following a series of focus groups with occupational therapists in the UK, is:

‘a partnership between the client and the therapist which empowers the client to engage in functional performance to fulfil his/her occupational roles in a variety of environments. The client participates actively in negotiating goals which are given priority and are at the centre of assessment, intervention and evaluation. Throughout the process the therapist listens to and respects the client’s values, adapts the interventions to meet the client’s needs and enables the client to make informed decisions’. (Sumsion, 2000, p.308).

The nature of client-centred practice in this definition is the active participation of the service user in assessments, prioritisation of goals, intervention and evaluation. Whilst not written directly for reablement services, section 10.2 of the statutory guidance for the Care Act, shares similarities with the definition of client centred practice for occupational therapists. The Care Act guidance states:

“The person must be genuinely involved and influential throughout the planning process, and should be given every opportunity to take joint ownership of the development of the plan with the local authority if they wish, and the local authority agrees. There should be a default assumption that the person, with support if necessary, will play a strong pro-active role in planning if they choose to”

(Department of Health, 2017)

Older people contributing to a report by the Audit Commission (2004) valued choice and control over their lives. Independence in their eyes was not defined as being able to do everything themselves, but having support in some areas so they could be independent in other areas. Information, finance, mobility, social activities, having a comfortable home and the role of equipment, adaptations and telecare were identified as components in contributing to a sense of well-being and independence. Older people value interdependence with others and being a valued

part of a social community (Audit Commission, 2004). Quality of life has been described as depending on 'social health' that involves engaging in friendships and participation in society (Harding, 1997).

Occupational therapists' standards of practice by the regulatory body state that occupational therapists should '*adopt an approach which centres on the service user*' and work in partnership with the service user and other members of the team (Health and Care Professions Council, 2013b). Similarly, publications from the occupational therapy professional body in the UK state that service users should be at the centre of an occupational therapist's practice, working in partnership with them and upholding a service user's rights to make choices (College of Occupational Therapists, 2015a; Royal College of Occupational Therapists, 2017).

1.4 Reablement and occupational therapy

Health and social care services labelled as reablement, have developed following the focus of Local Government legislation and guidance on prevention services, over the last 10 years. However, the term reablement was defined in the mid twentieth century with similarity to modern definitions. Wilcock (2002) describes two advocates of reablement: Mary S Jones and Dr Cooksey. Jones was an occupational therapist in the 1940s who preferred the term reablement to physical rehabilitation. She developed equipment to enable patients confined to bed to complete factory work for the war effort. She stated that the aims of reablement were:

'to improve a patient's capacities for living as normal a life as possible after disablement by illness or injury' (Wilcock, 2002, p.262).

Jones considered living a normal life as being able to earn a living and being able to enjoy life. She focussed on people earning a living by providing her patients with work that was interesting for the individual. The activity offered was also chosen and graded to work on the patient's remedial difficulties, such as grip or posture, to increase their independence.

At a similar time Dr Cooksey at King's College Hospital was in charge of a team of professionals in a physical medicine department. Cooksey's definition of

reablement was written in 1955 the same year that the word independence was officially adopted in the government publication 'Services for the Disabled'. In describing rehabilitation the publication said:

'One of the first essentials of rehabilitation is that the disabled should be as independent as possible in the personal activities of daily living such as dressing, feeding and hygiene'.

(Ministry of Labour and National Service, 1955 cited in Wilcock, 2002)

As well as identifying the need for work skills in line with Jones, Cooksey included daily activities in his definition of reablement:

'the restoration of physical and mental function after illness including the regaining of independence in daily living activities and in coping with disability as well as work skills' (Wilcock, 2002, p.261)

The reference to regaining independence in daily living activities bears resemblance to the definition used in this study, referring to learning and re-learning skills necessary for daily living.

'Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living'. (Care Services Efficiency Delivery, 2007)

The variance in the definitions demonstrates the influence of the medical model on occupational therapy, as previously highlighted. These early definitions of reablement refer to improving and restoring abilities and coping with disability, in contrast to accommodating for a disability in an alternative way, as in the current definition. In the following decade MacDonald edited a book on occupational therapy in physical rehabilitation and her aims of occupational therapy include both restoration and maintaining function:

1. *'The 'reablement' of the patient for restoration to former life and work.*
2. *Where this is not possible, the maintenance of existing function and the use of this in re-establishment of the patient in former work or in a new occupation'* (MacDonald, 1964, p.16)

Whilst MacDonald appears to focus on work in her aims, her discussion of the therapeutic use of activities highlights the importance of working with patients on maintaining or establishing independence in personal activities such as getting dressed and undressed, using the toilet and eating. MacDonald refers to the use of equipment to support people to carry out activities independently.

The focus of occupational therapy is on engagement in occupation, a group of activities with meaning to a person, as defined above (Section 1.3). The definition of reablement adopted for this study does not use the word occupation but refers to learning the skills necessary for daily living. The aim of learning these skills can be described in occupational therapy terminology as enabling someone to reach occupational performance, defined as:

‘choosing, organising and carrying out occupations in interaction with the environment’ (Creek, 2010, p.25)

The skills referred to in the definition of reablement may be likened to ‘occupational performance components:

‘abilities and skills that enable and affect engagement in tasks, activities and occupations. These can be categorised as eg. Physical, cognitive, psychosocial and affective’ (Creek, 2010, p.26)

These performance components are mirrored in the person element of the theoretical models previously described. Service users referred to reablement services can be described as occupationally deprived. They are unable to undertake daily occupations that they want or need to do. This statement, from the World Federation of Occupational Therapists, highlights how occupational therapists can support people; meeting the aim of reablement services.

‘Occupational therapy is a client-centred health profession concerned with promoting health and wellbeing through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support

their occupational engagement.'

(World Federation of Occupational Therapists, 2017).

This definition includes the goal of occupational therapy to enable people to participate in activities of everyday life and reflects the part of the reablement definition referring to supporting people to learn or relearn skills for daily living. For occupational therapists this includes working with people on skills or adapting the environment to support occupational engagement.

Occupational therapy pre-registration education focuses on the impact of physical and psychological disability on a person's ability to engage in occupations and includes the provision of equipment and adaptations and training in rehabilitation techniques (College of Occupational Therapists, 2014). These factors place occupational therapists in an ideal position to plan and facilitate reablement programmes for service users. The professional body for occupational therapists has published a position statement highlighting the positive impact occupational therapists can make in reablement services (College of Occupational Therapists, 2010).

1.4.1 Current reablement provision

The last update from the Care Services Efficiency Delivery (since disbanded) reported that 70% of the 152 Local Authorities with social services responsibilities had a reablement service in place (Care Services Efficiency Delivery, 2012). This compares to the previous report that named 57% of Local Authorities as having a reablement service (Care Services Efficiency Delivery, 2010). With the implementation of the Care Act (Department of Health) in 2015 encouraging the use of reablement services, it is likely that this figure has risen and will continue to rise. Research into the effectiveness of reablement services has found that reablement can improve the functional ability, or in occupational therapy terminology, occupational performance of service users and lead to reduced packages of care and therefore cost savings for Local Authorities (Glendinning and Newbronner, 2008; Le Mesurier and Cumella, 1999; Tinetti, Baker, Gallo *et al.*, 2002).

Whilst the Care Act 2014 promotes reablement it does not define how reablement services should be structured. The need for a common framework for reablement has been advocated (Bridges and James, 2012). Alongside differences in the types of staff employed within the reablement team, Local Authorities may also provide reablement in collaboration with another organisation, typically a domiciliary care agency, rather than provide the service 'in-house'. In 2012, twenty four of the 106 Local Authorities with reablement services in place had outsourced their reablement service to an independent domiciliary care provider (Care Services Efficiency Delivery, 2012). Scourfield (2006) advocates for the expansion of 'in-house' home care departments and argues that using independent care providers has provided additional responsibilities to Local Authorities in negotiating and monitoring contracts for services. Scourfield (2006) further argues that reduced cost of care at home for Local Authorities is based on independent providers paying lower salary rates with less benefits; and therefore quality of care is not maintained. Staff employed by the Local Authority may have difficulties influencing the training and skills of support workers employed by another agency. There is a paucity of research on reablement services involving the collaboration of two organisations.

Whilst there is no one staffing structure for the reablement services a recurrent role in reablement teams is that of the support worker. This important role involves working directly with service users to support them to increase their independence. If reablement services have developed from existing home care services it is important to consider the development of the support worker role from being a carer to being a reablement support worker. In a study of the management and effectiveness of home care, home care organisers and supervisors discussed the change in role from undertaking domestic tasks as a home help, to undertaking predominantly personal care tasks, such as assisting someone to use the toilet or have a wash, as a home carer (Sinclair, Gibbs and Hicks, 2000). They also reflect on being commissioned to undertake task focussed visits within a specified time. It has been recognised that working within limited time scales encourages support workers to do things for service users, leading to loss of skills and dependency on support by service users (Norris, 2008).

Reablement requires support workers to work with service users on the outcomes that they wish to achieve; supporting service users to do more for themselves. Some support workers have found it difficult to change from doing tasks for service users to standing back and enabling the service user to do more for themselves as they have expressed concern about seeing a service user struggle (Rabiee, Glendinning, Arksey *et al.*, 2009). However, in the same study of a number of different reablement services, support workers have readily accepted a new way of working and working in an enabling way has increased job satisfaction of support workers (Office For Public Management, 2010). As well as working with support workers within a reablement team occupational therapists may have a role in training of support workers in techniques to support service users to do more for themselves. This is discussed further in the realist synthesis in chapter three.

1.5 Rationale for this study

Reablement services are developing across the UK in response to government legislation promoting reablement as a feature of preventative services. Reablement aims to support people who have experienced poor health to engage in daily living activities; or in occupational therapy terminology: occupations. The core purpose of occupational therapy is to enable a person to participate in occupations important to them. Occupational therapists focus on three areas: the person; the occupation and the environment. Supporting someone to participate in occupations may involve working on a person's skills, adapting the occupation or changing the environment through, for example, the provision of equipment. Reablement studies have identified the provision of equipment as a role of occupational therapists (studies of reablement services will be discussed further in chapter three).

It is proposed that occupational therapists have a broader role than just providers of equipment, including working with reablement support workers. Occupational therapists' focus on supporting people to do more for themselves is essential training for support workers; particularly those from a home care background more familiar with a traditional approach of 'doing for' the person. There has been limited research focusing on the role of occupational therapists in reablement

services. Similarly there is a paucity of research on occupational therapists in reablement services working with support workers from a different organisation.

Occupational therapists are members of the team in some, but not all, reablement services, the broadness of their role remains unclear. This study critically evaluates the role of occupational therapists in reablement from the perspective of occupational therapists in practice, and members of the team who work with them. Including service users as direct participants in this study was considered to provide a perspective of the work of occupational therapists in reablement from receivers of the service. It was not possible to include service users as direct participants in this study. The reasons for this are discussed in chapter 4, section 4.7.1.2. However, observations of occupational therapists included visits to service users and notes of conversations held served as useful data to confirm or refute possible theories. Due to the paucity of research of reablement services provided in collaboration with an independent care agency, this research focussed in particular on reablement services involving two organisations. This element of the research adds to the research evidence concerning occupational therapists working with support workers and managers across organisations.

1.5.1 Study aim and research questions

This study aims to advance understanding of the role of occupational therapists in reablement services including the factors that influence their practice. The realist approach taken for this research will be presented in the following chapter.

This research sought to answer to following research questions.

- How can we critically understand the role and impact of occupational therapists working in reablement services?
- What is the experience of occupational therapists working in reablement services, and what contexts and mechanisms affect the outcomes of their practice for service users, carers and members of the reablement team?
- How do reablement managers and support workers work with, and perceive the role of, occupational therapists in reablement services?

1.5.2 Outline of thesis

Chapter 1. This chapter provides the context to the study, including a presentation of the historical background to both occupational therapy and reablement.

Chapter 2. The ontology and epistemology underpinning this study will be discussed and the realist evaluation approach to this research presented.

Chapter 3. This chapter presents a realist synthesis review of the literature focused on reablement and occupational therapy. Theories on the role of occupational therapists in reablement are developed from the literature for testing in the data collection phase of the study.

Chapter 4. This chapter presents the qualitative methodology and methods used in phase two of the research testing the theories identified in chapter three. It considers ethical issues including the influence of the researcher. This chapter concludes with a dense description of the participants and the case studies in this research, to provide context to the data collected.

Chapter 5. This chapter presents the findings of this study, confirming and expanding the theories developed in chapter three.

Chapter 6. This chapter presents a discussion of the findings and the contribution to current evidence and practice. A conceptual framework of effective practice is presented and elements of the framework are discussed and compared with existing literature.

Chapter 7. This final chapter summarises the research. The aims and research questions of the research are revisited. Strengths and limitations of the research are discussed and recommendations are made for professional practice and future research.

1.6 Conclusion

This chapter has discussed the development of the occupational therapy profession alongside the development of welfare state in the United Kingdom. It has considered the nature of being a profession alongside perspectives from the disability movement. Key legislation has been described that has guided social care

from provision of equipment and adaptations, to focussing on wellbeing and preventative services. The use of the word reablement has been explored and comparisons made to concepts of occupational therapy.

This chapter concluded with the rationale for this study and outlined the structure of this thesis to guide the reader on its content. The following chapter will consider in more depth the philosophical underpinnings and the methodology approach to this study.

2 Methodology and methods – phase 1: identifying realist programme theories

2.1 Introduction

This chapter presents the philosophical underpinnings to this study. It will outline the philosophy of positivism and interpretivism and their use in occupational therapy research. It will highlight how the philosophical position of critical realism led to a realist study design using qualitative methods. This chapter focuses on phase one of the research, the development of theories of occupational therapists in reablement services from the literature. Chapter four describes the methodology and methods of phase two of the research, the testing of the theories using a case study design.

This chapter will define and critique the key aspects of realist evaluation research and discuss the appropriateness of the approach to answer the research questions of this study. The stages of the realist approach to literature, a realist synthesis, will be described. The following chapter presents the realist synthesis itself. This chapter concludes with a reflection on the naming of this research as realist research rather than a realist evaluation.

2.2 Philosophical position

This study was conducted from the philosophical perspective of critical realism. Critical realism seeks to provide an alternative position to both positivism, the nature of one observable reality, and interpretivism, that the world is constructed by what we make of it (Alvesson and Sköldberg 2009). Prior to outlining the philosophical position of critical realism, the alternative ontological positions of positivism and interpretivism will be presented including their use in occupational therapy research and considerations for this study.

2.2.1 Positivism

Positivism is founded from the work of Auguste Comte (1798-1857) who sought for a 'positive' science of laws ascertained through scientific methods of observation, experiments and comparison (Crotty, 1998). Comte saw himself as a scientist and

was interested in whether the laws of the natural sciences could be utilised to investigate social sciences. Since the work of Comte positivism has remained linked to empirical science. Positivism is based on closed systems and notions of cause and effect. The relationships between phenomena can be predicted through hypotheses and studied through observation and measurement using quantifiable variables (Corbetta, 2003). Research underpinned by a positivist paradigm is concerned with 'what works?', with measures of validity adding confidence that interventions will be suitable for the occupational therapist's setting (Law and MacDermid, 2013; Polgar and Thomas, 2000).

Occupational therapy readily received the positivist approach through the early years of establishing as a profession, due to the influence of the medical profession, as described in chapter one. There have been a number of hierarchies of research evidence produced and randomised controlled trials (RCTs) remain at the top of the hierarchy pyramid (Evans, 2003). This hierarchy of research philosophy and method is further supported by the professional body for occupational therapists, the Royal College of Occupational Therapy, who cite RCTs trials as best evidence, in their guide to evidence based and evidence informed practice (College of Occupational Therapists, 2015b). RCTs continue to be utilised in recent occupational therapy research in, for example, the areas of driving, falls prevention, and stroke (Classen, Winter, Monahan *et al.*, 2017; Mikolaizak, Lord, Tiedemann *et al.*, 2016; Sackley, Burton, Mant *et al.*, 2015). Use of largely western evaluation tools to study occupation in other cultures with a positivist approach has been recognised as problematic. Phrases in such tools do not always translate easily or are appropriate to behaviour of other cultures (Hocking, Pierce, Shordike *et al.*, 2008).

Early thinking about this study considered defining and controlling variables to be able to compare different reablement services, using a quantitative methodology underpinned by positivist ontology. For example by comparing outcomes for service users who engaged with reablement services that included occupational therapists in the team compared to outcomes for service users engaging with reablement services without occupational therapy involvement. A feasibility randomised controlled trial (RCT) was recently undertaken in one Local Authority

of an intervention delivered by occupational therapists in a reablement service. This group were compared to 'usual care' of reablement without occupational therapy input (Whitehead, Walker, Parry *et al.*, 2016). The authors concluded that a RCT trial was feasible, acknowledging two issues to undertaking a full RCT. The first was difficulties in identifying a control group. During the study occupational therapists were introduced into one of the areas of the single Local Authority setting that had been designated for control group participants, thus limiting the availability of participants for his study. This issue is likely to remain as the development of reablement services continues throughout England, prompted by duties to provide prevention services under the Care Act (Department of Health, 2014). Each Local Authority makes decisions about staffing to fulfil the reablement role and that may involve introducing occupational therapists to an existing service. The second issue to undertaking a RCT of occupational therapists in reablement was identifying an appropriate outcome measure. One of the tools used during the feasibility study was the Barthel Index (Colin, Wade, Davies *et al.*, 2008), participants often reached the maximum score of the test within two weeks, whilst they were still working on goals. The authors suggest that the identification or development of an assessment tool for reablement would be beneficial (Whitehead, Walker, Parry *et al.*, 2016).

Measuring change using an appropriate assessment tool would provide some information on the effectiveness of occupational therapists in reablement services. This research seeks to describe and define the experiences of occupational therapists and their co-workers within reablement. To this end research founded on a positivist ontology was discarded as not suitable to answer the aims of my research.

There is a recognition that policy makers require a more diverse evidence base to make policy decisions in the complex areas of health care (Mays, Pope and Popay, 2005). Occupational therapists have been charged to consider the standpoint from which their practice is evaluated to represent the interests of both service users and the occupational therapy profession (Ballinger and Wiles, 2001).

2.2.2 Interpretivism

Interpretivism developed as a critique to positivism. It has been described as an 'anti-positivistic' paradigm, recognising the move from the concept of one observable reality, to the ontological concept that there are multiple realities constructed by the interpretations and meaning of the people in them (Cohen, Manion and Morrison, 2018; Holloway, 2005). Put simply, the social world is what we perceive it is. Understanding of the world is culturally and historically located, and so research undertaken from an interpretivist approach is provisional and dependent on context (Finlay and Ballinger, 2006; Houston, 2001).

For the purposes of this chapter interpretivism will be used as an umbrella term for a number of different perspectives. Interpretivism, social constructionism, phenomenology and hermeneutics have been grouped together to represent approaches that focus on human interaction and the situatedness of meaning-making (Cohen, Manion and Morrison, 2018; Pawson and Tilley, 1997). Denzin and Lincoln (1998) recognise that these approaches have a shared focus of understanding the world through the language and actions of people. They follow by plotting the development of interpretivism through hermeneutics and phenomenology. Other authors focus on social constructionism as an alternative to positivism (Alvesson and Sköldberg, 2009 ; Holloway, 2005), although both fall somewhere on a continuum. Social constructionism also has origins in phenomenology with Berger and Luckmann cited as pioneers in social constructionism through the publication of their book *The Social Construction of Reality* in 1966 (Alvesson and Sköldberg 2009). Constructivists focus on the view of reality through the people acting within it. The specific contrary view that constructivists take to the positivists' view of truth is the inclusion of perspective. Schwandt (1998) describes the constructivist view that:

'Knowledge and truth are created, not discovered by mind'.

(Schwandt, 1998, p.236)

Interpretivism has influenced research in social care, such as in Bytheway, Bacigalupo, Bornat *et al's.* (2002) edited book on research projects in social care. Whilst no discussion of philosophical underpinning are included in the description of the different studies, the research projects were shown to have interpretivist

foundations. The author states in the introduction that the research projects for the book were selected on their ability to describe how people experience and make sense of care. Creek (1997) advocates the adoption of an interpretivist approach to research in occupational therapy. She suggests that aligning occupational therapy with positivism leads to competition with medicine who are seeking 'cures'. She further suggests that doing so erodes the professional identity of the occupational therapy role in critically understanding the meaning of disability for service users and supporting what may be small changes to ability and independence (Creek, 1997). The need to consider research undertaken from both positivist and interpretivist epistemologies to support occupational therapy practice has been advocated (Tomlin and Borgetto, 2011).

Research founded on interpretivism was considered for this research to understand the experiences of occupational therapists and other team members of working in a reablement service. Qualitative research following an interpretivist approach focuses on the view and meaning of a phenomenon by the participants and whether there is a shared meaning between those participants. The goal of interviews in interpretivist research, for example, is not for breadth but depth of understanding (Rubin and Rubin, 2005). That said, interpretivism has been criticised for its primary focus on individuals and networks as constructing society, omitting any consideration of ideological power structures or underlying theories (Alvesson and Sköldberg 2009). Reablement services are established in Local Authority and/or National Health Service organisations with varying policies and practices. Understanding how these structures affected occupational therapy practice led me to the ontological position of critical realism.

2.2.3 Critical realism

Realism was developed as a critique of positivism's concept of one observable reality and interpretivism's focus on multiple realities based on human perception. In contrast, realism views reality as independent of our conceptions of it (Alvesson and Sköldberg 2009). Realism asserts that society is an open system involving social structures and the actions of people. As Collier defines:

'Society can only exist in so far as human agents act, reproducing and transforming the social structure' (Collier, 1994, p.171)

Realism focuses not only on observable events but on the causal mechanisms underlying events. The nature of reality is hierarchically stratified and mechanisms operate at different strata of reality (Archer, 1998; Danermark, Ekstrom, Jakobsen *et al.*, 2002). Realism has many iterations and is termed philosophic realism, scientific realism, experiential realism and critical realism to name a few and philosophical debates continue concerning the nature of realism (Maxwell, 2012). Critical realism is prominent in the social sciences and it is critical realism that underpins this study. Similarly to realism as a whole, proponents of critical realism are not homogenous in their perspectives of its essential features (Danermark, Ekstrom, Jakobsen *et al.*, 2002). Critical realism is widely associated, but not restricted to, the work of the British philosopher Roy Bhaskar, and Bhaskar's work. I don't propose to discuss all the complex elements of Bhaskar's particular theories of critical realism, instead this section focuses on the significant elements of critical realism that shaped the thesis and ultimately led to key decisions on the most appropriate epistemological considerations and methodology for the study.

As an open system Bhaskar asserts that there are three domains of reality. The first domain is the *empirical* domain; the world as we experience it through our senses. Whilst our experiences are a critical part of the world, Bhaskar asserts that they cannot be used to define the world, as in interpretivism (Bhaskar, 1978). The second domain is the *actual* domain. This domain describes the actual events whether we experience them or not. The third domain is described as the *real* domain. The real domain refers to the underlying mechanisms that can produce events. Something is '*real*' if it has a causal effect on behaviour. Bhaskar criticises the description of the world as purely empirical as an 'epistemic fallacy' reducing ontology to epistemology; that what we know can be reduced to how we know it (Bhaskar, 1978). The task of research undertaken with a critical realist ontology seeks to explore the real and establish how it relates to the empirical and actual domains.

Within the real domain mechanisms are described as generative mechanisms that are independent from the events they influence. Generative mechanisms only operate when they are triggered by particular conditions meaning that context is important. Consider a trip to the optician. The experience of attending the eye test would be in the empirical domain of Bhaskar's theory. The actual domain would be the optician in the eye test clinic, whether you attend or not. The real domain would be the underlying reason for attending the eye test, and is linked to the context. For example if you have difficulty reading a book, a concern about your health may be the mechanism that is triggered. If the context is that you are applying to be a fighter pilot, the underlying mechanism for attending the eye test may be to seek confirmation of good eyesight to support your job application.

Kemp (2005) suggests that the ontology of critical realism applied to social science is flawed, as it is not based on empirical arguments as it is in the natural sciences. Bhaskar (1978) asserts that society can only be known to exist; it can't be shown to exist. He likens this assertion to the natural world with the example of magnetism as an example of an underlying mechanism. Magnetism cannot be examined independently of the effects that it causes. Bhaskar asserts that it is not just mechanisms such as the magnetism that have causal effects, ideas and discourses can also be mechanisms. The research process in critical realism focuses on:

“the relation between the real world and concepts we form of it”

(Danermark, Ekstrom, Jakobsen *et al.*, 2002, p.15).

Critical realism focuses on both physical and social structures (contexts) and human agency, how people view their situation and the motives they ascribe to their actions.

Bhaskar describes a transformational model of social activity to explain the relationship between people and structures:

‘people do not create society. For it always pre-exists them and is a necessary condition for their activity. Rather, society must be regarded as an ensemble of structures, practices and conventions which individuals reproduce or transform, but which would not exist unless they did so’ (Bhaskar, 1998, p.216)

Social structures are the context in which people complete their actions and social interactions. Bhaskar uses the example of language that pre-exists before a person's birth, but may be transformed by people using that language. Society is considered as a product of structure and human agency (Bhaskar, 1998). The interplay between the two elements of structure and human agency is the focus of study from a critical realism perspective. Reablement services consist of a number of physical and social contexts that include: the environment where reablement takes place; the policy of the reablement service; and the resources available in the community. The motivation of the service user, the influence of family members and the experience and knowledge of occupational therapists are all aspects of human agency that, alongside the contexts previously described, that may affect the outcome of reablement.

2.2.4 Philosophical and methodological underpinnings to this study

Critical realism underpins this study as it is concerned with the behaviour of occupational therapists in practice within the structures of reablement services. The aim of this study is to investigate the real domain, to discover the causal mechanisms that underpin human behaviour leading to positive and not so positive outcomes of the role of occupational therapists in reablement services

2.3 Realist evaluation

This study uses a realist evaluation design based on a realist philosophy of science. This study favours the approach of British theorists Ray Pawson and Nick Tilley, following the well-trodden path of other researchers engaging in realist research in health and social care contexts, particularly in the UK (Cheyne, Abhyankar and McCoury, 2013; Greenhalgh, Humphrey, Hughes *et al.*, 2009; Pearson, Hunt, Cooper *et al.*, 2013; Walshe and Luker, 2010). Pawson and Tilley have written widely about realist evaluation including books and articles providing guidance to the approach (Pawson, 2006b; Pawson, 2013; Pawson and Manzano-Santaella, 2012; Pawson and Tilley, 1997).

Pawson and Tilley introduced the approach of realistic evaluation (Pawson and Tilley, 1997), later amended to realist evaluation. I will use the term realist

evaluation to describe the approach of Pawson and Tilley and reserve the specific title of realist synthesis for my review of the literature described in section 2.5.

Pawson cites the work of seven authors including critical realists Roy Bhaskar and Margaret Archer as a foundation on which his work on realist evaluation is built (Pawson, 2013). In the same publication Pawson goes on to discuss the philosophy of Bhaskar in more detail agreeing with Bhaskar's belief in generative causation, the need for theory to guide the understanding of a complex society and that interventions are transformed by human agency. He continues by disputing other propositions of Bhaskar including generative mechanisms being located only in societal structures, as one example. Porter (Porter, 2015b) responding to Pawson's critique of critical realism contends that there are greater similarities in realist evaluation and critical realism than Pawson suggests. In his response Pawson confirms that he was initially 'impressed' by Bhaskar's early work on generative causal explanation (Pawson, 2015, p.56). Pawson asserts his stance as a methodologist interested in practicalities and positions himself as 'some kind of realist' (Pawson, 2013, p.xix)

As realists, realist evaluation as described by Pawson and Tilley (1997) seeks not to answer the question of whether a programme (or intervention) works, but considers what it is about a programme that causes it to work (Pawson and Tilley, 1997). Realist evaluation includes the influence of context and asserts that it is not the intervention that works per se, but there are mechanisms that cause the intervention to lead to positive or negative outcomes (Pawson and Tilley, 1997). Realist evaluation aims to analyse the underlying causal mechanisms, or theories of change, behind how and why complex social interventions work, or do not work. The commonly quoted phrase for the aim of realist research is to consider '*what works, for whom in what circumstances*' (Pawson, 2006b, p.78).

The expanded phrase includes the factor of why. Realist evaluation seeks to establish the contexts that lead to positive, or negative, outcomes. The aim of the research is to establish:

‘why does a programme work in Wigan on a wet Wednesday and why does it fail in Truro on a thunderous Thursday’
(Pawson and Manzano-Santaella, 2012, p.78)

2.3.1 Mechanisms, contexts and outcomes

Realist evaluation involves the development of a conceptual model with configurations of context, mechanisms and outcomes, as demonstrated in figure 1. **Mechanisms** within the context of realist evaluation are also concerned with the reason behind intervention; the unseen reactions, choices and capacities of people that impact on the success, or not, of a programme (Pawson, 2006b).

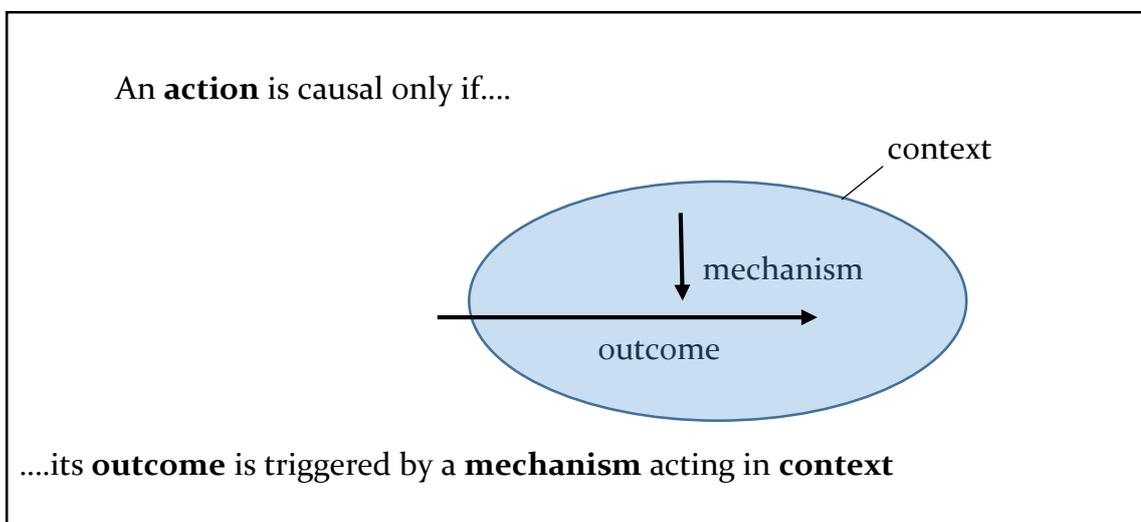


Figure 1 Generative causation with context, mechanism, outcome configurations (Pawson and Tilley, 1997, p.58 reproduced with permission of SAGE Publications)

Contexts in realist research may include physical, institution and legislative considerations. Contexts are the circumstances in which mechanisms occur leading to an outcome (Pawson, 2006b)

Outcomes are the resulting positive or negative actions or consequences of the mechanism triggered by the context within the intervention. Realist evaluation does not search for outcome regularities; that an intervention will work every time under certain circumstances. Instead, the aim of the research is to identify demi-regularities or patterns of outcomes (Pawson, 2006b).

Within realist evaluation contexts, mechanisms and outcomes are kept together in a configuration, rather than separated out. The context triggers the mechanism, also phrased as the context leading to the mechanism ‘firing’. This in turn leads to

a particular outcome. An understanding of the configuration of contexts, mechanisms and outcomes is developed into what is described as programme theory. Programme theories seek to identify the intended outcomes of an intervention and the mechanisms and contexts that affect the success, or otherwise, of that intervention (Pawson, 2006b).

2.3.2 Occupational therapy as a complex intervention

Realist evaluation classifies complex interventions as theories, based on a hypothesis. Providing these interventions will lead to an improved outcome of some kind (Pawson, Greenhalgh, Harvey *et al.*, 2005). Complex interventions are also embedded in existing social systems (Pawson, Greenhalgh, Harvey *et al.*, 2005, 2005).

Complex interventions are those with multiple elements with different aims (Moore, Audrey, Barker *et al.*, 2015). Complexity also describes interventions that may or may not be complex that occur within complex adaptive systems consisting of people with different objectives who adaptive their behaviour to improve outcomes from their perspective (Greenwood-Lee, Hawe, Nettel-Aguirre *et al.*, 2016). Occupational therapy has been described as a complex intervention due to the multiple components of practice leading change through mechanisms considering 'person(s)-in-context' (Pentland, Kantartzis, Clausen *et al.*, 2018, p.45). One of the intended outcomes for reablement is the improved ability of the service user to do more for themselves. This involves working with people in the complexity of their own physical and social contexts including wider health and social care systems. Different social systems provide different contexts in terms of physical attributes, for example location and finance, staff abilities and relationships. Complex interventions are described as active, in that they involve the knowledge and reasoning of a number of parties (Creek, Ilott, Cook *et al.*, 2005). In the case of reablement this includes managers, staff in the reablement team and the service users and carers they work with. As such reablement can be described as a complex adaptive system as managers, occupational therapists and service users may have different perspectives and outcomes for reablement that may be in conflict. Observation enables the identification of patterns of behaviour

and opportunities of complex adaptive systems (Plsek and Greenhalgh, 2001) and this was one of the reasons for including observation in this research.

Research undertaken from a positivist perspective using an apposite research method such as a randomised controlled trial (RCT) would see reasoning of different parties as a 'contaminant' to the research process; as the aim would be to examine whether the intervention alone leads to a greater outcome (Pawson, Greenhalgh, Harvey *et al.*, 2005). Despite the hierarchy of evidence placing RCTs as the goal standard of research, it has been recognised that the evaluation of complex interventions, such as reablement services, benefit from wider approaches to research. The Medical Research Council published an updated framework for the design and evaluation of complex interventions (Craig, Dieppe, Macintyre *et al.*, 2006). Whilst the framework promotes the use of experimental methods with randomisation of participants, the framework recognises that this method is not feasible in some situations where the researcher has no influence on the implementation of the intervention. The Medical Research Council asserts the value of evaluating the process of why an intervention works alongside measures of outcomes, to assess fidelity and implementation, identifying causal mechanisms and contexts that lead to different outcomes (Craig, Dieppe, Macintyre *et al.*, 2008). An evaluation of outcomes alone may not describe the contexts, structures and mechanisms that support positive outcomes of an intervention; this being the data essential to realist research. In relation to occupational therapists in reablement no RCTs have yet been undertaken. The feasibility RCT study undertaken (Whitehead, Walker, Parry *et al.*, 2016) identified issues with identifying a control group and an appropriate outcome measure as previously described.

In contrast to this, realist evaluation seeks to explain the reasons for effectiveness, and non-effectiveness, of an intervention; the reasoning of parties involved in the intervention will contribute to this. Occupational therapists have been encouraged to understand the complexities of their intervention to ensure best practice (Pentland, Kantartzis, Clausen *et al.*, 2018). This research seeks to analyse the mechanisms that link to the impact of occupational therapists in reablement services, in essence, what works in what circumstances. Before describing the methodological approach to this study it is important to critique the approach to

be followed to provide insight into possible issues that may occur during the research process.

2.3.3 Critique of Pawson and Tilley's realist evaluation

Realist evaluation is a relatively recent addition to the research arena with the authors introducing the approach in 1997 (Pawson and Tilley, 1997). As a developing approach authors have critiqued the philosophical underpinnings to realist evaluation particularly in relation to the link between realist evaluation and critical realism as described in section 2.3 above (Lacouture, Breton, Guichard *et al.*, 2015; Porter, 2015b).

Realist evaluation has been criticised for treating all types of evidence equally asserting that this challenges the robustness of the theory (Dixon-Woods, Agarwal, Jones *et al.*, 2005). This specific criticism relates to the realist synthesis stage of the approach. Pawson (2006b) advocates analysing a wide variety of data in formulating and testing theory. This range of data includes published studies and unpublished service evaluations and opinion. This is in contrast to a systematic review of the literature in which criteria are set and research studies reviewed and reduced to those with high statistical power and the results aggregated into the findings of the review (Pope, Mays and Popay, 2007). The aim of reviewing literature in realist research is to begin to understand the mechanisms and contexts behind how interventions produce positive and negative outcomes. Information on contexts and mechanisms is frequently found in the narrative account of findings rather than statistical information. As such, aspects of research studies may be useful in developing theory rather than the subject of a research study alone (Pawson, 2006a). This is an important reason for including research with a variety of methodologies when searching for potential programme theories. That being said, realist research recognises the importance of evaluating quality of data within research outputs. Realist research considers the relevance and the rigour of the research (Pawson, 2006b). These two concepts and the appraisal approach taken in this study are discussed in detail in the following chapter.

The following sections and the following chapter describe aspects of realist evaluation and the methods used in this study. These are presented in a linear

format and somewhat disguise the iterative and challenging nature of the task. Two reviews of realist evaluation undertaken in the area of health services research identified the approach as resource and time intensive (Marchal, van Belle, van Olmen *et al.*, 2012; Salter and Kothari, 2014).

A frequent critique of realist evaluation is the difficulty in identifying the context mechanism outcome configurations (Lacouture, Breton, Guichard *et al.*, 2015; Marchal, van Belle, van Olmen *et al.*, 2012; Punton, Vogel and Lloyd, 2016; Salter and Kothari, 2014). Developing context mechanism outcome configurations from real life situations has been described as a struggle requiring researchers to have high levels of skill and an understanding of their subject (Linsley, Howard and Owen, 2015; Punton, Vogel and Lloyd, 2016). Difficulties defining mechanisms and contexts, and distinguishing between them, is a difficulty that hinders development of context mechanism outcome configurations (Marchal, van Belle, van Olmen *et al.*, 2012; Salter and Kothari, 2014). A number of authors made suggestions concerning mechanisms to support researchers in defining different concepts. Dalkin, Greenhalgh, Jones *et al.* (2015) suggest disaggregating mechanisms into resources and reasoning with context positioned between these two concepts. In line with critical realist philosophy Porter (2015a) suggests dividing mechanisms into programme mechanisms and contextual mechanisms and treating human agency as a separate concept. In response Pawson asserts that context mechanism outcome configurations are a 'signpost not an instruction manual' (Pawson, 2016, p.137) and suggests that Porter's alternative formula might suggest a mechanistic approach. Lacouture, Breton, Guichard *et al.* (2015) reviewed the definitions of mechanisms used by researchers and concluded that the definition is evolving. Research terms were used as described in the publication of Pawson (2006b) to guide this research.

2.4 Methodology

Realist evaluation does not favour either qualitative or quantitative methodologies. The qualitative approach taken to test and develop theories in this study is described in chapter four. In order to test the programme theory in a realist evaluation, first the context, mechanism, outcome configurations need to be

identified. Pawson (2006b) presents an alternative to the systematic review of literature to identify programme theories, known as a realist synthesis. The following sections describe the process of identifying initial programme theories through a realist approach to the literature: a realist synthesis.

It is important to consider the trustworthiness of a realist approach to the literature. A discussion of quality in research is discussed more fully in chapter four. The sections below and the following chapter seeks to provide detail of the process undertaken in the realist synthesis to demonstrate methodological quality and transparency. Reflexivity is also discussed more fully in chapter four. At this stage is important to note that the researcher is an occupational therapist and as such I was aware of the influence I may have on identifying possible theories. Throughout the process of the realist synthesis and wider data collection I kept a reflexive diary to record my thoughts about the process and ensure that themes identifying were evident in the literature.

2.5 Realist synthesis

A realist synthesis is a method of reviewing literature within realist research (Pawson, 2006b). The realist synthesis itself is presented in the next chapter. Chapter three describes the process of undertaking the realist synthesis with details of the literature search strategy and analysis of the literature. This section introduces the reader to the stages of the realist synthesis and the differences between a realist synthesis and a systematic review of the literature. The linear presentation of the following sections does not reflect the iterative nature of this process. Emmel (2015) described the process of identifying theories, seeking to define those theories and having further ideas as a process of zigzagging in realist research. The linear presentation in this chapter and the next are for the benefit of the reader to comprehend the different stages of the research.

A realist synthesis involves developing an initial programme theory about what works, for whom, in what circumstances and why. Pawson (2006b) outlines a number of stages to completing a realist synthesis, recognising that these stages may overlap, see table 2.

1. Identifying the review question (Mapping the territory)
--

- | |
|--|
| <ol style="list-style-type: none">2. Searching for primary studies3. Quality Appraisal4. Extracting the data5. Synthesizing the data6. Disseminating the findings |
|--|

Table 2 Stages of the realist synthesis (Adapted from Pawson, 2006b)

This chapter will discuss the first stage of identifying the research question and stages two to five will be presented in the following chapter. Stage six ‘disseminating the findings’ will not be discussed, suffice to say that this thesis represents the first stage of disseminating the findings of this study. Journal articles planned to be developed from this study will support the dissemination of the findings.

2.5.1 Identifying the research question

The first stage refines the purpose of the realist synthesis review of the literature. Whilst Pawson titles this stage ‘Identifying the review question’, it could be argued that this title does not represent the complexity of defining a set of questions about the topic under study and starting to identify configurations of contexts, mechanisms and outcomes to be tested during the following stages. Indeed Pawson describes this first stage as time-consuming and ongoing throughout the course of the synthesis, reflecting the overlapping nature of the stages (Pawson, 2006b). Pawson’s sub-heading of ‘*Mapping the Territory*’ begins to describe the process of this stage in which the researcher considers the implementation of the programme under study, the reasoning and feedback of stakeholders, and links to policies and contextual influences on the programme theory (Pawson, 2006b).

It is worth pausing to consider how the word programme is used in realist research. The purpose of a realist synthesis is to develop and test programme theory. Programme is a term used for the subject under study. In other studies this has included electronic learning for medical staff and housing relocation programmes (Jackson, Langille, Lyons *et al.*, 2009; Wong, Greenhalgh and Pawson, 2010). These topics lend themselves to the title of a programme. In contrast this realist synthesis is concerned with the topic of occupational therapists in reablement services. Within health and social care this would not be termed as a programme, rather as

an intervention or a service. This chapter will retain the language of realist research using the term programme when discussing the development of programme theory. The reader should consider the word programme interchangeable with the word intervention.

In *'Mapping the Territory'* of occupational therapists within reablement services it is important to define what this study means by reablement services. In chapter one the history of the use of the term reablement within occupational therapy and government legislation and guidance was outlined. This study focusses on the current provision of reablement in community settings, following the UK government's promotion of reablement services, for example in the Care Act, 2014, discussed in chapter one. This study uses the definition of reablement adopted by the Royal College of Occupational Therapists (College of Occupational Therapists, 2010) from the Care Services Efficiency Delivery (2007):

'Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living.'

The Care Act 2014, and the legislation and guidance preceding the Act, does not provide a structural framework for reablement services in terms of team members, referral sources or intervention undertaken. The contexts surrounding occupational therapy involvement may be different according to local policy and commissioning agreements. To begin to identify programme theories regarding the type of outcomes that result from occupational therapists working in reablement services, and for whom they apply and why, I approached occupational therapists who work in reablement services.

Pawson (2006b) advocates discussion with stakeholders linked to the programme, and experts in the field, to identify possible programme theories on how the intervention works, or not, in practice. Stakeholders in this case included experts in the field, the occupational therapists and occupational therapy managers of reablement services. An email request was forwarded via the Social Services Network of the Royal College of Occupational Therapists asking for information on occupational therapists in reablement services in the UK, with particular reference

to services with another organisation involved in the services. From the responses received those who identified that their reablement service met my criteria of involvement of occupational therapists in a reablement service consisting of two organisations, were contacted by telephone for further information. The data from this contact with experts in the field is presented in the following chapter.

Information from occupational therapists in the field helped to structure my review of the literature. Details of the databases searched, search terms and exclusion and inclusion criteria are described in the following chapter in the second stage of '*Searching for primary studies*'.

2.6 Summary

This chapter has presented the philosophical underpinnings to this study. It has identified realist research as an appropriate approach to understanding the role of occupational therapists in reablement services and factors that support, or hinder, their effectiveness. This chapter has discussed phase one of this research: the realist synthesis review of the literature within realist research. The following chapter presents the realist synthesis. The methodology and methods of phase two, the testing of the theories developed in the realist synthesis, are presented in chapter four. Phase two was the phase of data collection and analysis utilising a qualitative case study design. This chapter concludes with an explanation of this research being classified as realist research in contrast to a realist evaluation.

2.6.1 Realist research rather than a realist evaluation

This research is named realist research rather than a realist evaluation. It is an exploratory study of programme theories from stakeholders and the literature, explored and expanded through qualitative methodology of data gathered through case studies. The qualitative methodology was key in identifying the contexts and mechanisms explained by the participants in the study. Whilst rich data was achieved, the proposed outcomes of occupational therapists working in reablement service could only be anecdotal using this method. Quantitative evaluation of the suggested outcomes from the different context, mechanism, outcome configurations is necessary to test the programme theories fully and understand the resulting patterns, or demi-regularities, in the programme. Absence of this

evaluation has been identified as producing artificial results (Pawson and Manzano-Santaella, 2012). This study can be considered as an essential preliminary study to identify contexts and mechanisms from occupational therapists and the staff they work with. A further study is required to evaluate the outcomes identified using a quantitative methodology to fully test the theories identified.

3 Realist synthesis

3.1 Introduction

This chapter presents the findings of the realist synthesis review of the literature following the realist research approach of Pawson and Tilley (1997), outlined in the previous chapter. To introduce this chapter, I will briefly recap on the approach of realist research and the aim of a realist synthesis. Realist research is concerned not just with what works but the underlying reasons why programmes (interventions) work or do not work. A realist synthesis seeks to identify context, mechanism, outcome configurations from different sources including existing literature and conversations with stakeholders in the field (Pawson, 2006b).

The realist synthesis presented in this chapter examined a broad range of sources from experts in the field to position statements, research studies and published opinion about occupational therapists in reablement services. From these sources an initial programme theory of occupational therapists in reablement services was produced, using the technique of developing ‘if...then’ statements (Pawson, 2006b). These programme theories were synthesised with other literature to develop the theories to be tested, expanded and defined in the following chapters comprising phase 2 of the research. Chapter Four discusses the case study methodology undertaken and provides a dense description of the case studies in the study to provide contextual information for the reader. Chapter Five presents the qualitative findings from the case studies.

This chapter will present the five stages of the realist synthesis, as presented in table 3, in a linear format, for the ease of the reader, recognising that the stages did overlap. For example extracting the data in stage four, led back to searching for further primary studies to define the programme theories (stage two).

- | |
|--|
| <ol style="list-style-type: none">1. Identifying the review question2. Searching for primary studies3. Quality Appraisal4. Extracting the data5. Synthesizing the data |
|--|

Table 3 Five stages of the realist synthesis (Adapted from Pawson, 2006b)

3.2 Identifying the review question

The previous chapter introduced the first stage of the realist synthesis: identifying the research question. This stage includes identifying possible outcomes of a programme and the contexts and mechanisms that lead to specific outcomes. This chapter continues with information gathered from contacting experts in the field, encouraged by Pawson (2006b), to initiate discovery of how an intervention works, or not, in practice.

3.2.1 Contact with experts in the field

To begin to identify how occupational therapists work in reablement services an email was sent to the Social Services Network of the Royal College of Occupational Therapists (described in the previous chapter and included in Appendix A). Occupational therapists were asked about the nature of their reablement service, whether occupational therapists were included in the team and if so the nature of their role. Fifteen email responses were received. As the particular focus of this study was reablement services with an independent organisation involved, telephone contact was made with five responders who identified that their reablement service met his criterion. Telephone discussions included details of the reablement service, the role of the occupational therapists and the outcomes of occupational therapists' intervention.

Information gathered from the email responses and telephone conversations highlighted outcomes for two different groups: service users and reablement staff; as a result of contact with an occupational therapist. Figures 2 and 3 provide pictorial illustrations of the process and outcome for both of these groups.

3.2.2 Outcomes for service users

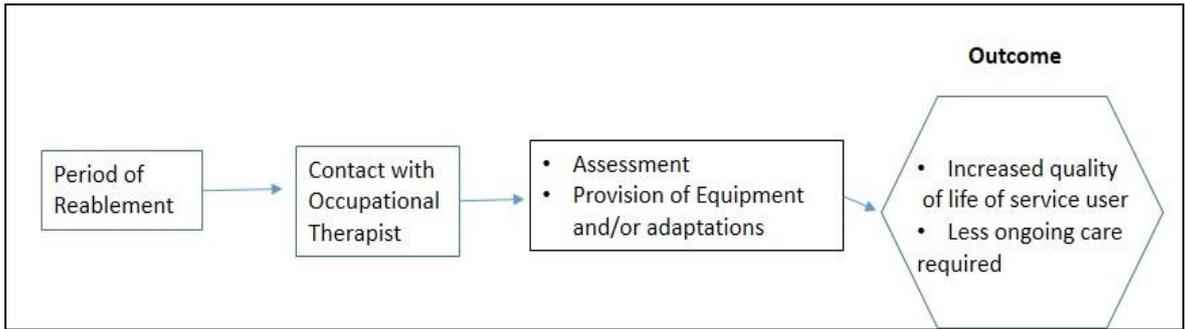


Figure 2 A pictorial representation of the intervention and outcome for service users

Following engagement with the reablement service, service users came into contact with occupational therapists at two stages: assessment and provision of equipment and/or adaptations. Some managers described the role of occupational therapists in completing assessments with service users when they were referred to the service, agreeing goals and formulating the reablement plan to meet those goals. In other services occupational therapists did not assess every service user at the beginning of reablement but would visit service users referred to them from the wider reablement team, largely to provide equipment and adaptations. Managers identified increased quality of life for service users and a reduction in the amount of care required, as outcomes of occupational therapy intervention in their reablement service, both anecdotally and evidenced through internal service evaluations.

3.2.3 Outcomes for members of the reablement team

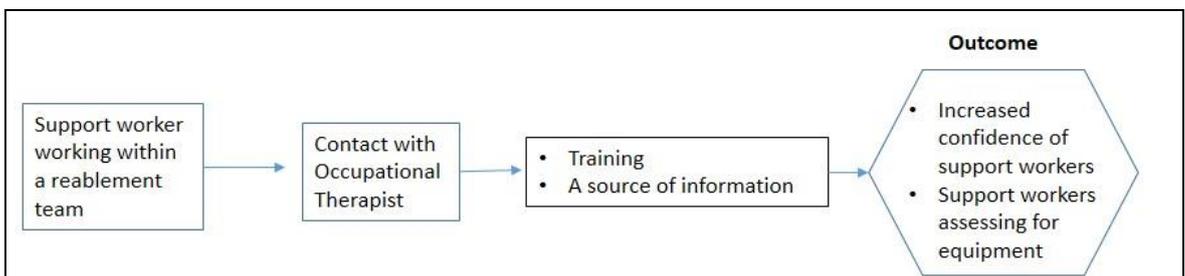


Figure 3 A pictorial representation of the programme and outcomes for support workers

Support workers were members of the reablement team identified as benefitting from having contact with occupational therapists in the team. Occupational therapists provided formal training and were a source of information for support

workers. These activities enabled some support workers to assess for equipment and increased the confidence of support workers in their reablement skills.

The information gathered from occupational therapists in reablement practice, depicted in the representations above, provided some initial thoughts on the role of occupational therapists in reablement services and the outcomes of their intervention. Attitude of support workers was identified as a possible underlying mechanism affecting positive outcomes. In particular, the attitude of support workers to taking on a reabling ethos; supporting service users to do more for themselves by standing back, rather than doing things for service users. Occupational therapists reported that support workers who had worked in more traditional home care settings were often those who found working in a reabling way more difficult. Support workers employment history can be considered as a context relevant to the programme theory.

These responses from the occupational therapists identified possible contexts, mechanisms and outcomes to develop the programme theory on occupational therapists' role and intervention in reablement services. This '*mapping of the territory*' (Pawson, 2006b) helped to define the questions for the next stage of reviewing the literature to identify further context mechanism outcome configurations. The review of the literature was underpinned by the research questions for this study as follows:

- How can we critically understand the role and impact of occupational therapists working in reablement services?
- What is the experience of occupational therapists working in reablement services, and what contexts and mechanisms affect the outcomes of their practice for service users, carers and members of the reablement team?
- How do reablement managers and support workers work with, and perceive the role of, occupational therapists in reablement services?

The review of the literature aimed to address aspects of the research questions by focusing on the following specific questions:

- What are the different roles of occupational therapists in reablement services

- What are the contexts and mechanisms that lead to positive, or negative, outcomes for service users, carers and members of the reablement team?

3.3 Stage 2 Searching for primary studies

This first search of the literature focussed on occupational therapists in reablement services to begin to establish whether the opinions of the occupational therapists in practice were mirrored in the literature. The following section describes the consideration of terms used for reablement in the UK and throughout the world, and the inclusion and exclusion criteria used to identify relevant literature.

3.3.1 Search terms

There are a number of different terms used to describe reablement services that are often used interchangeably. In the UK the terms re-ablement and enablement are often used synonymously. Following a review of the reference lists in a number of articles on reablement the terms ‘restorative services’ and ‘restorative care’ emerged as the terminology for services with close similarities to reablement, used primarily in Australia and the United States of America (USA). Restorative care services have been asserted as comparable to reablement services in the UK. Definitions of restorative care are said to vary but focus on restoration and maintenance of physical function, promoting independence and improvement of quality of life (King, Parsons, Robinson *et al.*, 2012). The focus on restoration of ability and improvement of quality of life fit with the aspects of enabling people to accommodate their illness and relearn skills for daily living in the definition of reablement used in this study. Before deciding to include studies from outside the UK I also compared the definition of occupational therapy in Australia and the USA with the definition of occupational therapy in the United Kingdom (World Federation of Occupational Therapists, 2013):

Australia

Occupational Therapy is a health related profession using selected activity to prevent and overcome many physical, emotional or social disabilities in people of all ages. The objective is to promote, maintain or restore functional independence in daily living skills.

United States of America

The practice of occupational therapy means the therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of participation in role and situations in home, school, workplace, community, and other settings...Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.

United Kingdom

Occupational therapy enables people to achieve health, well-being and life satisfaction through participation in occupation.

There are clear similarities between these definitions in terms of enabling people to complete daily living tasks for themselves. It can be assumed that occupational therapy practice in each of these countries has the same ethos. This led to the decision that literature from these countries would be included in the literature search. The contexts of the different reablement services may be different, for example funding may be via a Local Authority in the UK or insurance in the USA. The realist approach supports the identification of different contexts and their influence on mechanisms and outcomes of reablement.

The focus on restoring ability in reablement can be affiliated with rehabilitation. Therefore rehabilitation was also included as a search term for reablement. To identify the maximum number of sources on reablement, the following terms were used, searched for in all fields.

- Reablement
- Re-ablement
- Enablement
- Restorative services
- Restorative care

- Rehabilitation²

There are a number of terms used to describe adult social care. The following terms were used in the literature search. All of these terms were searched as specific phrases in the title and abstract fields of the literature.

- Social care
- Social services
- Adult care
- Local Authority
- Community services
- Home care

The numerous terms for reablement were combined with the terms for social care to identify relevant reablement services. The results were then combined with a search for ‘occupational therap*’ in any field of the publication to identify reablement type services with an adult social care element including occupational therapists or occupational therapy.

3.3.2 Databases searched

A total of 14 databases were searched covering health, social care, sociology and humanities to locate relevant literature from a broad range of sources. A list of the databases can be found in Appendix B. No filters were used in the search (for example, type of study) to ensure that a wide variety of sources of literature were included in the search, including quantitative and qualitative research studies and opinion pieces. Grey literature was included to search for practice guidelines and reports from professional bodies such as the Royal College of Occupational Therapists.

² Searches on the word rehabilitation produced a very high number of search results (in excess of 177,000). Therefore, the results of the search for rehabilitation was limited to results including any of the terms for social services as described above.

3.3.3 Inclusion criteria

The initial review of literature had inclusion criteria of reablement services with a social care element, involving occupational therapists. Whilst the study focusses on reablement services developed following recent government legislation, searches were not limited by date to enable reablement type services studied prior to the legislation to be screened for possible programme theory identification. Literature was included up to 2014, the year the literature search was undertaken. The legislation promoting reablement, Care Act 2014 pertains to adults only and therefore this realist synthesis had an inclusion criterion of reablement services for adults. The word adults was not included as a search term initially during literature searches to ensure searches identified as much literature as available on reablement services. Exclusion criteria were developed during the literature searches as different themes arose that were not relevant to answering the synthesis questions. The inclusion criteria was further defined at the screening stage, see table 4.

3.3.4 Exclusion criteria

The exclusion criteria for the realist synthesis were developed iteratively as certain terms produced results in subjects unrelated to reablement as defined for this study. For example, the term enablement produced a significant number of sources from general practice. Enablement was linked with a patient enablement instrument. A search of the literature found 'Patient enablement' defined as '*the extent to which a patient is capable of understanding and coping with his or her health issues*' (Hudon, Fortin, Rossignol *et al.*, 2011, p.1). Therefore these articles were excluded.

Searching on the word reablement produced a significant number of articles on specific reablement for people with poliomyelitis. These articles were excluded due to the specific nature of this health condition and the health intervention given.

For a number of searches a high number of articles were found, for example rehabilitation and all terms referring to social care. A review of the titles and abstracts of the initial search results identified articles on student education and work with children. Other studies were commissioned for a particular service user group such as people with learning disabilities or mental health problems. These

articles were excluded at this stage as the focus of the realist synthesis was on context and mechanisms affecting outcomes in reablement services for adult social care in general rather than a specific service user group. In light of screening of initial results the following terms were added as exclusion criteria:

- Child*
- student education
- “Learning disabilities”
- “learning disabled”
- “mental health”
- psych*

3.4 Results of literature search

Using the inclusion and exclusion criteria, searches were made of 14 databases (see Appendix B), as described above. Appendix C provides an example search strategy and appendix D a table of hits obtained from each database. Following removal of duplications 2297 articles were identified and the citations for these articles were exported to Endnote reference management software. The titles and abstracts of the articles were screened for relevance using the refined inclusion criteria in table 4. The full text of the article was sought for articles that did not provide sufficient information in the title or abstract to ascertain whether the article met the criteria. Figure 4 provides a flow chart of the process of screening and appraising the articles found from the literature search.

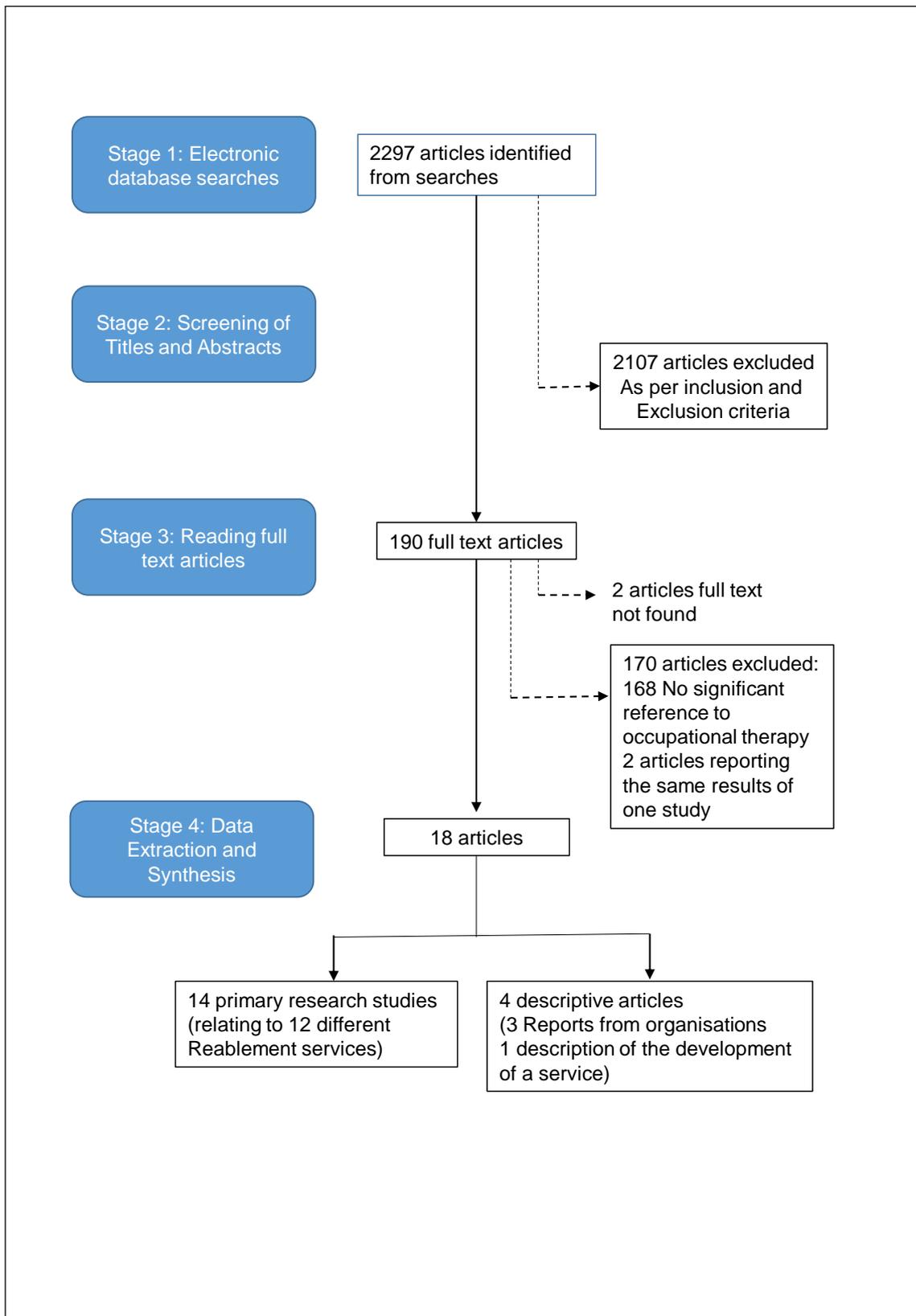
Table 4 Screening inclusion criteria

Definition of reablement	Services working with people with physical difficulties or disabilities to assist them to learn or re-learn to undertake daily living activities.
The reablement service	A service provided entirely by social care or by health and social care, worldwide. A service with occupational therapists (health or social care funded) either in the team or having input into the team
Who the service is for	Adults with a variety of physical, mental health or learning difficulties. (Services designed for a particular service user group, for example people who had had a stroke, were excluded as were services exclusively for people with mental health problems or learning disabilities).
Location of intervention	In a service user's own home.

Following the screening of titles and abstracts, 190 articles potentially met the inclusion criteria. The full text was appraised for these articles. The majority of research articles discussed the development and structure of the reablement service. Within this description many only made a passing reference to occupational therapy, for example occupational therapists were listed in tables of members of the team. Eighteen articles included the role of occupational therapists in reablement services in sufficient detail to identify aspects of programme theories.

The stage of screening demonstrated the overlap of different stages of the realist synthesis, described by Pawson (2006b). During the search for programme theories as part of stage 2 of the synthesis, the quality of the studies was appraised (stage 3 of the realist synthesis) and data was extracted (stage 4 of the synthesis). Prior to presenting the initial programme theory identified from the eighteen relevant articles of the literature search, I will address quality appraisal within realist research.

Figure 4 Flowchart of literature search



3.5 Stage 3 Quality appraisal.

During a realist synthesis literature is reviewed to identify, and then seek to confirm or dispute, programme theories of why and how a programme works. To this end a variety of literature is sought with no hierarchy assumed in terms of research type. It has been asserted that including all types of literature challenges the robustness of the theory (Dixon-Woods, Agarwal, Jones *et al.*, 2005). To counteract this challenge some researchers appraise research as having ‘thick’ or ‘thin’ description (O’Campo, Kirst, Tsamis *et al.*, 2011); others prepare a series of questions to consider the rigour of the research (Walshe and Luker, 2010). The focus of appraising the literature in a realist synthesis is to extract data of relevance to the programme theory. In this way, it may not be the study in its entirety that is relevant but an abstract of it. For example, it may be the discussion section of a research study that identifies possible mechanisms that triggered an outcome, such as a training programme triggering the mechanism of confidence in staff, leading to an outcome of competence in undertaking a task. Consequently it is the extract from the research that can add to the programme theory, that should be appraised (Pawson, 2006b). Appraising an element of a study limits the use of standardised quality appraisal checklists that seek to evaluate the entire study. In realist research the extract of the literature relevant to the programme theories is appraised using two factors: relevance and rigour.

3.5.1 Relevance

This is the primary decision about whether any of the results from a study are relevant to identifying or developing programme theories (Pawson, 2006b). The relevant results may not be the main topic of the study and therefore may not be evident in the title or the abstract of a research paper. An element of the study may link to an identified context or underlying mechanisms of the programme theory from other literature. Whilst titles and abstracts were the primary elements of a study read in the screening process, the search terms for occupational therapists was searched in all fields during the search. Full text of articles were read to identify the aspect related to occupational therapists during the screening process when this was not evident within the title or abstract. Each article was appraised on a case by case basis during the full text screening, extraction and synthesis stages.

For each of the primary research studies it was the qualitative element of the study that contained aspects that contributed to the programme theory. This was often an element of a larger quantitative study of a reablement service.

3.5.2 Rigour

Once an element of a study is appraised as relevant, it is then appraised for rigour. This assessment of rigour does not necessarily consider the robustness of the research as a whole, it is concerned with the trustworthiness of the element of study of interest to the programme theory (Pawson, 2006b). Topics such as the method of the study, sample size and analysis are assessed with respect to the particular aspect of the results relevant to the programme theories. The assessment of rigour is concerned with whether specific conclusions of the research related to the theory being tested are supported by the results obtained.

Pawson (2006) does not advocate use of critical appraisal documentation in order to assess the rigour of the elements of a study that could contribute to the programme theory. Nevertheless I wanted to ensure I maintained consistency in my appraisal between different studies. I opted to design and utilise an appraisal sheet to guide my appraisal of rigour, a blank sheet is included in Appendix E. The appraisal sheet included space to record realist concepts of possible outcomes, contexts and mechanisms. There were also sections to appraise the credibility of findings in terms of research design and results presented. The aspects of relevance in the article were recorded alongside the rigour of the results.

3.6 Stage 4 Data extraction

Each of the eighteen articles identified through the search of the literature was read in full to search for aspects of research studies that could contribute to the research questions of the realist synthesis. Identifying potential programme theories was not a straightforward process. Whilst studies frequently documented aspects of the context of the reablement service, the mechanisms that were activated by the intervention of an occupational therapist were less overt.

Information about occupational therapy practice was largely found in the description of reablement teams, and data from interviews and focus groups with

occupational therapists and other reablement team members that were undertaken within larger studies of reablement. The qualitative aspects were largely gathered from small numbers of occupational therapists and managers. Within the time period of the research (up to 2014) one evaluation of a reablement service focussed exclusively on the role of occupational therapists in reablement services (Latif, 2011). However, the published report lacks credibility in its findings as outlined in table 5. A number of articles published by organisations reported on the value of occupational therapists in reablement services and research studies echoed the positive outcomes of occupational therapists for service users, carers and other reablement team members. Information on contexts and mechanisms that support practice was most often found within the discussion sections of research papers that included direct quotes from participants.

3.6.1 If...then propositions

To support the development of programme theories, five 'if...then' propositions were defined. 'If...then' propositions are a method of demonstrating the hypothesis of the context mechanism configuration thus, *if* the programme activates underlying mechanisms within particular contexts *then* this will lead to a particular outcome (Pawson and Manzano-Santaella, 2012). Writing the theories in this way helped to compare different propositions between studies. Each 'if...then' proposition includes the contexts (C), mechanisms (M) and outcomes (O) identified for the theory using the letters C, M or O in brackets. The propositions are numbered for ease of reference in the following two sections, and referenced in table 5.

Extracting information from the articles in the literature search supported 'if...then' propositions on the outcome of occupational therapy practice in two areas: service users and carers; and reablement team members. This echoes the responses from occupational therapists in the field, as described above.

3.6.1.1 Outcomes for service users and carers

1 If occupational therapists are involved in goal setting and designing reablement plans with service users (C) as other members of the reablement team have recognised the need for the occupational therapist's skills and knowledge (M) then

realistic, structured reablement plans enable support workers to work with service users to increase their independence in daily occupations (O)

2 If occupational therapists have knowledge of the impact of disability on a service user's ability to carry out daily occupations they need and want to do (C) and complete assessments and goal setting with service users (C) using a holistic approach (M) then the occupational engagement of service users in areas of their life increases (O)

3 If occupational therapists provide timely access to equipment (C) and service users and carers accept that equipment (M) then service users can do more for themselves (O)

3.6.1.2 Outcomes for reablement team members

4 If occupational therapists are involved in regular contact with reablement support workers including training sessions (C), support workers increase their skills and confidence (M), feel valued (M), practice in a reabling way with service users (O) and report increased job satisfaction (O)

5 If occupational therapists are involved in training reablement support workers (C), role blurring can occur (M) and support workers can assess for and provide equipment for service users (O)

The 'if...then' propositions were a starting point in defining how occupational therapy practice works, and for whom and why. Table 5 presents a description of the articles appraised in the data extraction stage, including notes on appraisal of the information and how each article contributed to the theory. During data extraction contexts, mechanisms and outcomes were given codes for example C1 equates to the first context identified, O1 the first outcome and M1, M2 and so on, represent mechanisms. This method was used to identify similarities in each of the areas over the different articles. This coding is included in table 5.

3.6.2 Programme theories

The five 'if...then' propositions, developed from the eighteen articles, were further developed into four programme theories. It is important to note that each article contributed to the programme theories, no one study alone included all the

theories. 'If...then' proposition number five was not developed into a fifth programme theory. This proposition concerned the mechanism of role blurring and provision of equipment by support workers, as a result of training from occupational therapists. This aspect was omitted from the programme theories as the role blurring by support workers was only evident in one study (Kent, Payne, Stewart *et al.*, 2000). Role blurring was mentioned in one other study (Le Mesurier and Cumella, 1999) in relation to other roles. As this topic was mentioned in a low number of studies it was decided that the programme theories concerning recognition of the occupational theory role, equipment and the training of support workers, encompassed 'if...then' proposition five. The programme theories developed are numbered one to four, as follows:

1 Recognition of the skills and knowledge of occupational therapists by staff in reablement teams determines the degree to which occupational therapists support service users and carers.

2 The skills and knowledge of occupational therapists can be utilised in assessment, goal setting and the development of plans in a holistic way for reablement to support the occupational engagement of service users in all areas of daily life.

3 The timely provision of equipment increases the independence of service users and supports carers in their caring role.

4 Occupational therapists contact with support workers, including involvement in training, increases the skills and confidence of support workers and assists support workers to work in a reabling way.

Table 5 Evaluation of articles to identify theory

(* The title of the last column is 'if..then' proposition number, representing the number(s) of the proposition(s) that the article contributed to)

Authors (date) [Country]	Type of study and methods used	Total Participants/ sample size	Quality Appraisal		Context (C) mechanism (M) outcome (O) configurations	*
			Relevance	Rigour		
Baker, Gottschalk, Eng <i>et al.</i> (2001) [USA]	Report on the development of a restorative model of care. Methods: team meetings, training conference, focus group with service users.	8 support workers (known as home health aides) included in training	Occupational therapists are referred to in the section on the training of support workers on activities of daily living skills and use of equipment	Comprehensive explanation of the development of the service is recorded. Small number of support workers involved in the study with no formal evaluation of change as a result of training. Results include reports from support workers that they felt valued, no direct quotes were included to confirm this statement.	C1 – Occupational therapists involved in training support workers M1 – support workers feel valued as members of the team O1 – Support workers work in a reabling way.	4
Calderdale Council and Yorkshire and Humber Joint Improvement Partnership (2010) [UK]	Qualitative Study to identify best practice of reablement in one region. Methods: Interviews with commissioners, service managers, care managers, team leaders, frontline staff, users and carers.	Number of participants not stated	Details of the different services includes details of the role of occupational therapists. Recognising the value of occupational therapy input is presented as an (cont. overleaf)	Report does not record numbers of participants or numbers of interviews and focus groups undertaken. Few direct quotes are used. Case studies from the different services in the region provide the most substantive detail of the work of occupational therapists with individual service users.	C2 – Therapeutic knowledge of Occupational therapists M2 – informed risk taking O2 – Increased ability of service users C3 – Occupational therapists involved in assessments M3 – holistic approach O3 – increased occupational engagement of service user	2,3, 4

Authors (date) [Country]	Type of study and methods used	Total Participants/ sample size	Quality Appraisal		Context (C) mechanism (M) outcome (O) configurations	✳
			Relevance	Rigour		
Cont, from previous page	Focus groups with managers, team leaders and frontline staff.		example of good practice. .	Therefore the CMO configurations are based on limited data.	C4 – timely access to assessment for equipment M4 – service user accepts equipment O2 – Increased ability of service user C1 – Occupational therapists involved in training support workers M5 – Increased skills and confidence of support workers O1 – Support workers work in a reabling way.	
Care Services Efficiency Delivery (2007) [UK]	Questionnaire sent to 150 Local Authorities in England asking about the nature of the reablement services. Case studies of five reablement services	98 responses to questionnaire Information gathered from 13 Local Authorities with a reablement service.	No formal evaluation of the role of occupational therapists. Occupational therapists referred to in questionnaire responses and case studies.	Information on the role of occupational therapists is credible as it is received from the Local Authorities about their own service. The information is often brief, and unclear whether comments have originated from occupational therapists in the service. The lack of rigorous collection of data limits transferability.	C1 – Occupational therapists involved in training support workers M5 – Increased skills and confidence of support workers O1 – Support workers work in a reabling way. C4 – (delay in) timely access to equipment O4 – delay in service user completing their reablement C5 – service users with complex needs M6 – recognition of skills and knowledge of occupational therapist O5 – comprehensive support plan written for service user	1,3, 4

Authors (date) [Country]	Type of study and methods used	Total Participants/ sample size	Quality Appraisal		Context (C) mechanism (M) outcome (O) configurations	✱
			Relevance	Rigour		
Chinouya and Cook (2012)	Magazine article focussing on one reablement support worker (the article is based on a research study, abstract of a presentation about the study provided details of all participants)	Report of one carer from larger qualitative study of 22 service users, 8 managers and 40 council paid carers.	The authors include the role of occupational therapists in training support workers	Study undertaken by academics independent of the service. Comprehensive description and direct quotes are included in the article to support credibility of the comments.	C1 – Occupational therapists involved in training support workers M1 – support workers feel valued as members of the team M5 – Increased skills and confidence of support workers O1 – Support workers work in a reabbling way	4
Harris (2010) [UK]	Evaluation of a reablement pilot. Quantitative analysis of demographics of service users and functional change via Barthel Index scores. Qualitative data from service user questionnaires (n=51) and semi structured meetings with staff Separate report also written by the occupational therapist.	170 service users. Number of staff involved in meetings not recorded	The comments by the occupational therapist are the relevant aspect of the study. The quantitative information collected is general information with no specific reference to occupational therapists.	The comments about occupational therapy are the opinion of a single occupational therapist with experience of working in the reablement team. There is no ability to triangulate the comments with other data to increase the reliability and credibility of the data.	C3 – Occupational therapists involved in assessments M6 – recognition of skills and knowledge of occupational therapist O3 – increased occupational engagement of service user C4 – timely access to assessment for equipment M4 – service user accepts equipment O2 – increased ability of service user C5 – service users with complex needs M5 – [lack of] Increased skills and confidence of support workers O6 – Service user put at potential risk	1,3, 4

Authors (date) [Country]	Type of study and methods used	Total Participants/ sample size	Quality Appraisal		Context (C) mechanism (M) outcome (O) configurations	✱
			Relevance	Rigour		
Jones, Baxter, Curtis <i>et al.</i> (2009) Glendinning, Jones, Baxter <i>et al.</i> (2010) Rabiee, Glendinning, Arksey <i>et al.</i> (2009) [UK]	Large mixed methods research comparing five Local Authority reablement services with four Local Authority standard home care services. Methods: Quantitative: Self Perceived Health question, Perceived quality of life 7 point likert scale, Health- related quality of life measure (EQ-5D), Adult Social Care Outcomes Toolkit (ASCOT) Interviews with managers/ Observations of reablement services (26 visits in total), focus groups with front line staff	Interviews with eight managers One focus group in each study site. 37 people in total took part in focus groups, including 3 occupational therapists.	Role of occupational therapists included in discussion article on the organisation and staff membership of reablement teams. Occupational therapists are primarily referred to with reference to provision of equipment.	The use of comparison sites supports identification of impact of reablement services for service users. The qualitative questionnaire was piloted with a Local Authority not part of the study prior to data gathering. The use of observations, interviews and focus groups supports triangulation of the data and increases the credibility of the findings. Occupational therapists provided support to just less than one third of service users in the reablement services. The small number of occupational therapists who participated in focus groups (n=3) limits contribution of occupational therapists to the study findings.	C3 – Occupational therapists involved in assessments O13 – Increased quality of life of service users C4 – [delay in] timely access to assessment for equipment No overt mechanism O4 – delay in service user completing their reablement C4 – timely access to assessment for equipment M4 – service user accepts equipment O2 – Increased ability of service users O10 – carer able to continue in caring role C5 – service users with complex needs M6 – recognition of skills and knowledge of occupational therapist O2 – Increased ability of service users	1,2, 3

Authors (date) [Country]	Type of study and methods used	Total Participants/ sample size	Quality Appraisal		Context (C) mechanism (M) outcome (O) configurations	*
			Relevance	Rigour		
College of Occupational Therapists (2010)	Position Statement on occupational therapists in reablement by the UK professional body for occupational therapists	n/a report	The article is very relevant as its focus is on the added value of occupational therapists in reablement services	Article is opinion from the professional body for occupational therapists in the UK with references to a number of research examples to support comments.	C2 – Therapeutic knowledge of Occupational therapists M3 – holistic approach O5 – comprehensive support plan written for service user	2
Kent, Payne, Stewart <i>et al.</i> (2000) Norris (2008) [UK]	Evaluation of a reablement pilot Quantitative analysis of demographics of service users and outcome of reablement. Qualitative data gathered from case files, shadowing the reablement team, meetings, discussions, interviews and a questionnaire. Interview with Local Authority Manager	25 case files analysed Numbers of staff involved in meetings, discussions and interviews not stated	Description of the service includes relevant reference to the role of occupational therapists.	Short case study includes some detail of the role of occupational therapists. Report is externally evaluated by a University, reducing possibility of bias if pilot was evaluated by the Local Authority that commissioned it.	C3 – Occupational therapists involved in assessments M6 – recognition of skills and knowledge of occupational therapist O5 – comprehensive support plan written for service user C1 – Occupational therapists involved in training support workers M7 – role blurring O7 – support workers trained to assess for and provide equipment.	2,5

Authors (date) [Country]	Type of study and methods used	Total Participants/ sample size	Quality Appraisal		Context (C) mechanism (M) outcome (O) configurations	✱
			Relevance	Rigour		
Latif (2011) [UK]	Mixed methods study on the impact of an occupational therapist working in a reablement service	Number of service users evaluated not recorded. One occupational therapist in the reablement staff team.	The whole report is relevant as it focusses on the value of occupational therapists in reablement services.	The report lacks detail to provide credibility to results. Graphs demonstrating improvement do not state how many service users were in evaluation. The report presents results from a questionnaire to staff. No details are given on the details of the questionnaire or how many responses were received.	C4 – timely access to assessment for equipment O2 – increased ability of service user C1 – Occupational therapists involved in training support workers M5 – Increased skills and confidence of support workers O1 – Support workers work in a reabling way	3,4
Le Mesurier and Cumella (1999) [UK]	Evaluation of a reablement service Quantitative methods: cost analysis and measurement of functional ability (actual measure not stated). Report includes comments from team members with no reference to the method of collecting this data	Number of all service users not stated. 100 service users contacted for follow up information. Details of different roles in the team given	Summary of the key features of reablement includes relevant information on the role of occupational therapists within the team.	Article provides comprehensive details of case studies of the role of reablement and associated costs. Article quotes comments from managers and other team members.	C9 – Occupational therapists involvement in goal setting M7 – role blurring O3 – increased occupational engagement of service user C6 - Shared office space M7 – role blurring O8 – multidisciplinary approach	1,5

Authors (date) [Country]	Type of study and methods used	Total Participants/ sample size	Quality Appraisal		Context (C) mechanism (M) outcome (O) configurations	*
			Relevance	Rigour		
Littlechild, Bowl and Matka (2010) [UK]	Mixed methods evaluation of a reablement service. Quantitative element: Canadian Occupational Performance Measure (COPM) with service users (n=38), a self report of performance of an activity and satisfaction levels. Review of case notes of 57 service users Qualitative element: Interviews and focus groups with staff and service users.	Interviews: 5 occupational therapists, 6 occupational therapy assistants, 11 managers 36 service users interviewed at baseline and 33 2-9 months post intervention Focus group with 20 social workers	This comprehensive evaluation of an occupational therapy led service is relevant concerning both the role of occupational therapists in the service and the effectiveness of the service for service users.	This study is defensible in its design. The Canadian Occupational Performance Measure (COPM) is a suitable tool for evaluating change in occupational performance and satisfaction relating to occupations important to service users. Quantitative scores from the COPM are confirmed by data from qualitative interviews. The report makes use of direct quotes from service users to support discussion.	C4 – timely access to assessment for equipment M8 – confidence of service users O9 – increased satisfaction in completing daily occupations O10 – carer able to continue in caring role	3
Petch (2008) [UK]	Comment on the role of occupational therapists in reablement from a social care research organisation.	n/a	The short article has relevance to the synthesis as it concentrates on the role of occupational therapists in reablement services	Opinion report of one author based in occupational therapy practice, using findings from reablement research and quotes from the professional body for occupational therapists in the UK to support her argument.	C2 – Therapeutic knowledge of Occupational therapists C5 – service users with complex needs M6 – recognition of skills and knowledge of occupational therapist O2 – Increased ability of service users	1

Authors (date) [Country]	Type of study and methods used	Total Participants/ sample size	Quality Appraisal		Context (C) mechanism (M) outcome (O) configurations	✱
			Relevance	Rigour		
McLeod and Mair (2009) [UK]	Mixed methods evaluation of a new reablement service compared to a control group matched by age and hours of support required, who received standard home care. Quantitative element collated information on levels of care and costs before and after a period of reablement. Qualitative element consisted of focus groups and interviews with service users and members of the reablement team	Quantitative evaluation of 90 service users. Interviews with 14 service users receiving reablement and 3 service users receiving usual home care. 16 staff involved in focus groups or interviews, including 3 occupational therapists.	The qualitative element of the evaluation is the most relevant as this contains detail of the practice of the team, the role of occupational therapists within service users and other team members.	The three occupational therapists interviewed in the study, although small in number represent the total number of occupational therapists working in the team. The evaluation is defensible in design with comprehensive recording of the aims of the evaluation and methods chosen. Findings are supported by quotes from interviews and focus groups adding to the credibility of the findings.	C4 – timely access to equipment M8 – confidence of service users O2 – increased ability of service users C5 – service users with complex needs C7 – screening meeting M6 – recognition of skills and knowledge of occupational therapist O2 – Increased ability of service users C8 – Regular meetings with team M1 – support workers feel valued as members of the team O12 – Increased job satisfaction of support workers. C9 – Occupational therapists involvement in goal setting M6 – recognition of skills and knowledge of occupational therapist M9 – Improved skills and confidence of reablement team members O5 – comprehensive support plan written for service user C9 – Occupational therapists involvement in goal setting M10 – Motivation of service users O2 – Increased ability of service users	1,3, 4

Authors (date) [Country]	Type of study and methods used	Total Participants/ sample size	Quality Appraisal		Context (C) mechanism (M) outcome (O) configurations	✱
			Relevance	Rigour		
Riley, Vincent and Whitcombe (2008) [UK]	Online questionnaires sent to all Local Authorities in England. Focus groups with occupational therapists and occupational therapy managers in social care and practice educators.	647 questionnaire responses from occupational therapists (representing 121 out of 150 Local Authorities in England and 53% of occupational therapists in social care). 123 responses from managers, from 82 Local Authorities.	The aspects of the report of relevance are the responses to the questions about expanding the role of occupational therapists and case studies given on examples in practice.	There is evidence of rigorous conduct of the research. Comprehensive information on the aims of the project, methods and analysis undertaken. Questionnaires were piloted in other UK countries before distribution. The high number of respondents adds credibility to the findings. Case studies used in the report add further detail.	C2 – Therapeutic knowledge of Occupational therapists M6 – recognition of skills and knowledge of occupational therapist O2 – Increased ability of service users C3 – Occupational therapists involved in assessments C4 – timely access to assessment for equipment M4 – service user accepts equipment O2 – Increased ability of service users O11 – reduced care costs	1,2, 3
Social Care Institute of Excellence (SCIE) (2011) [UK]	Briefing by social care improvement support agency	n/a	The briefing is focussed on the role of occupational therapists in reablement services. The briefing (continued overleaf)	The case studies provide sufficient detail to illustrate the points made. However there is no reference to the method of how the case studies were acquired to provide further credibility to the discussion.	C2 – Therapeutic knowledge of Occupational therapists C1 – Occupational therapists involved in training support workers M6 – recognition of skills and knowledge of occupational therapist	1,2, 4

Cont.			describes findings of other research discussed in this realist synthesis. The aspect of relevance is the case study examples used.		<p>O1 – Support workers work in a reabling way</p> <p>C3 – Occupational therapists involved in assessments</p> <p>M2 – informed risk taking</p> <p>O2 – increase ability of service users</p>	
-------	--	--	--	--	---	--

3.6.3 Search for articles to confirm or refute the theories developed

The programme theories outlined above were developed from the eighteen studies of the first literature search, table 5. To develop the theory further, Pawson (2006) advocates that once programme theories are identified researchers should search for evidence of that theory, rather than confine any search to the specific subject under investigation. The first stage of the second review of the literature involved returning to notes made from the 190 full text articles screened in stage 3 of the first literature search (figure 4). Some of these articles had not contained sufficient information to contribute to the 'if...then' propositions, however they may contain information relating to some aspects of the theory identified. A second search of the literature was undertaken that was not limited to research in reablement services but was restricted to occupational therapists working with adult service users in the community. The topics included for the second literature search focussed on key aspects of the programme theory, namely: assessment and goal setting; provision of equipment; and occupational therapists' training of support workers in social care services (see appendix F for details of search terms and numbers of articles screened).

During the screening process 102 articles were identified for appraisal of the full text. Twenty six articles were identified as including relevant data to add to the programme theories. A table illustrating how each of the articles from both literature searches were used to identify or contribute to the programme theories, is included in Appendix G.

3.7 Stage 5 Synthesising the data

This section presents a discussion of the literature that supported the development of the four programme theories. The theories will be considered in turn recognising that there is overlap between the different theories.

3.7.1 Programme theory 1 recognition of the role of occupational therapists

Recognition of the skills and knowledge of occupational therapists by staff in reablement teams determines the degree to which occupational therapists support service users and carers.

Box 1 Programme theory one - recognition of occupational therapists

The first programme theory focusses on how and when occupational therapists are utilised in reablement service (box 1). The recognition of the skills and knowledge of occupational therapists by other team members appears to be a key mechanism underlying the role of occupational therapists in reablement services.

Leaders of the occupational therapy profession in the UK consider reablement as a core area for occupational therapists. Prior to the current drive for Local Authorities to commission services, such as reablement, to support people to be independent, in 1994 Professor Averil Stewart used her inaugural professorial lecture to stress that enablement is the focus of occupational therapy, enabling people to engage in daily living occupations to influence their own health (Stewart, 1994). Occupational therapy is based on client centred practice; supporting people to complete the occupations that are important to them (Creek and et al., 2005).

More recently the professional body for occupational therapists in the UK published a position statement on the added value of occupational therapists in reablement services. The statement considers reablement as a core element of occupational therapy education and cites the unique skills and training of occupational therapists as being essential in reablement services, to enable service users to participate in occupations in all areas of their lives. The article includes brief examples of research with occupational therapists in a variety of situations that led to the increased independence of service users, reduced care needs and supporting carers in their role (College of Occupational Therapists, 2010). Once professionally qualified, occupational therapists largely gravitate towards working in either the health or social care sector. Petch (2008) views this as a positive standpoint enabling occupational therapists to identify the needs of individuals, and suggest who may be best placed to support them, transcending organisation

boundaries. This can be particularly relevant in integrated health and social care reablement services.

3.7.1.1 Occupational therapists' views of their role in reablement

Occupational therapists in practice have asserted their aspiration to move into reablement roles. A group of 100 occupational therapists from 30 different Local Authorities attended a workshop at a personalisation conference and identified reablement amongst the skills that they could contribute to the personalisation agenda (Nosowska, 2010). In a larger scale survey of occupational therapists working in social care settings 47% of the 647 respondents advocated an expansion of their role into areas such as reablement and prevention services; asserting that this expansion could improve outcomes for service users. The survey gathered data on the current role of occupational therapists and found the predominant area of practice for 90% of occupational therapists was recommendations for equipment and adaptations, and assessments of housing needs (Riley, Vincent and Whitcombe, 2008). The occupational therapist involved in a pilot reablement service in East Dorset echoed a limited role as a provider of equipment within the reablement service. She asserted that her skills and knowledge of condition management such as managing falls, memory problems and simplifying tasks were not requested and concluded that this was due to lack of awareness of her skills by other members of the team (Harris, 2010).

Where reablement services are led by occupational therapists there is evidence of a wider role for occupational therapists. As well as assessing for specialist equipment, occupational therapists also provide advice and guidance to support workers in energy conservation, fatigue management and moving and handling (Social Care Institute For Excellence, 2011b). Silver Chain are a home care agency in New Zealand. They developed a Home Independence Program (HIP) that has demonstrated a greater improvement in outcomes and less need for ongoing care for service users in the HIP compared to a control group (Lewin, De San Miguel, Knuiman *et al.*, 2013; Lewin and Vandermeulen, 2010). A report of the initial pilot of a HIP includes the aims of the service to promote active engagement in daily living activities through task analysis, work simplification and assistive technology (Lewin, Calver, McCormack *et al.*, 2008). The HIP manual for staff, lists work

simplification, energy conservation and assistive technology as interventions that an occupational therapist would be involved with. Dressing techniques, fine motor skills, stress management, advice on sensory impairments and coping with cognitive difficulties are also domains of the occupational therapist in the team (Silver Chain, 2007).

The Department of Health commissioned the Care Services Efficiency Delivery (CSED) to complete the largest study of reablement to date, thereafter referred to as the CSED study. Reablement services in five different Local Authorities were compared with standard home care services in five other Local Authorities. Multiple publications on the reablement services and the short term and long term outcomes for service users, have resulted from the research (Gerald Pilkington Associates, 2012; Jones, Baxter, Curtis *et al.*, 2009; Newbronner and Chamberlain, 2008; Rabiee, Glendinning, Arksey *et al.*, 2009; Wilde and Glendinning, 2012). Two of the reablement services in the CSED study had occupational therapists as members of the reablement team. Teams without occupational therapists in the team has access to occupational therapists from other teams. Service users were referred to occupational therapists if they were considered to have complex needs (Rabiee, Glendinning, Arksey *et al.*, 2009). This demonstrates the mechanism of other staff members recognising the level of skills and knowledge required to best support service users within the context of complex needs.

3.7.1.2 The context of complexity

Responses to a questionnaire to Local Authorities in England on the development of reablement services asserted that occupational therapists were employed in teams to work with people with 'complex care needs' (Care Services Efficiency Delivery, 2007). Occupational therapists have been associated with complex needs previously (Creek and *et al.*, 2005); although there is no clear definition of complex in this context. Numerous descriptions of complex needs exists within health and social care (Rosengard, Laing, Ridley *et al.*, 2007). The standard dictionary definition of complex refers to something consisting of many different and connected parts (Oxford University Press, 2017). Rankin and Regan (2004) expand this definition within social care, describing the connected parts as having depth and breadth.

In a review of a new reablement service in Edinburgh occupational therapists worked with 39% of the service users referred to the service. These service users were recognised as having complex needs (McLeod and Mair, 2009). Examples of intervention undertaken with service users with complex needs includes designing intensive rehabilitation packages for service users, particularly those with moving and handling needs (Calderdale Council and Yorkshire and Humber Joint Improvement Partnership, 2010; Care Services Efficiency Delivery, 2007). Meetings with occupational therapists and reablement managers to screen referrals are a method of identifying service users that may benefit from input from occupational therapists (Calderdale Council and Yorkshire and Humber Joint Improvement Partnership, 2010; McLeod and Mair, 2009). Such screening meetings help to identify where specialist skills of occupational therapists are required and where more generic working is appropriate.

There are other contexts that support reablement staff to recognise the skills and knowledge of occupational therapists. Working in interdisciplinary teams, including training together, has led to a greater understanding of each other's roles with staff reporting a 'heightened awareness' of the need for referral to other disciplines in the team (Nancarrow, 2004). The mechanism of recognising the skills and knowledge of occupational therapists has another outcome for reablement staff. An increased understanding of the role of occupational therapists by social workers has supported a change in ethos from provision of care to promoting independence (Littlechild, Bowl and Matka, 2010). Sharing office space encourages informal discussions and it has been suggested that this supports some blurring of professional boundaries, including training support workers to issue equipment (Le Mesurier and Cumella, 1999; Norris, 2008).

3.7.2 Programme theory 2 holistic practice by occupational therapists

The skills and knowledge of occupational therapists can be utilised in assessment, goal setting and the development of plans in a holistic way for reablement to support the occupational engagement of service users in areas of daily life

Box 2 Programme theory two - holistic practice

During the early years of the development of reablement services in Local Authorities, the use of occupational performance assessments was identified as a priority area for investigation. One hundred and ninety people, from 100 Local Authorities attended a workshop hosted by the Care Services Efficiency Delivery (CSED), to launch a discussion document on reablement. The workshop did not raise sufficient support to develop a common assessment tool and the CSED collated information on assessment and evaluation of reablement services from seven case study areas. Four of the seven case studies utilised occupational therapists to complete assessment and/or identify goals with and write support plans for service users (Care Services Efficiency Delivery, 2007).

3.7.2.1 Assessments

A review of reablement services in 15 Local Authorities in the Yorkshire and Humber region identified varying roles for occupational therapists in each of the services. In three of the services occupational therapists completed assessments with services users, agreed outcome goals for the period of reablement and in some services also developed a plan to meet the service user's goals (Calderdale Council and Yorkshire and Humber Joint Improvement Partnership, 2010). During the interviews and focus groups with front line staff in the Calderdale area, the occupational therapists emphasised the breadth of their knowledge. They asserted that their knowledge of medical conditions enabled them to take greater risk than other social care workers might, in designing reablement programmes to support service users to meet their outcomes and increase their independence. Whilst there are no comments from service users to confirm this claim reported from the study, occupational therapists' training in medical, physical and psychological impacts on disability, and holistic approach has been asserted as essential for developing reablement plans (College of Occupational Therapists, 2010). Occupational therapists have been utilised to complete occupational performance assessments to support the planning of reablement support. Following initial assessment by a member of the reablement team service users have been referred for further assessment by occupational therapists to increase occupational engagement in areas such as meal preparation and managing fatigue (King, Parsons, Robinson *et al.*, 2012). A case study included in the evaluation of a pilot reablement service in

Leicester referred to support workers asking the occupational therapist to assess the service user's ability to use a kettle to establish the level of safety risk to the service user (Kent, Payne, Stewart *et al.*, 2000). The results of the assessment determined how support workers worked with the service user as part of the reablement plan. The report quotes a team member recalling the role of the occupational therapist as "*invaluable in helping the team to set realistic, achievable goals*" (Kent, Payne, Stewart *et al.*, 2000, p.29).

Occupational therapists who participated in focus groups during the CSED study, described previously, highlighted the usefulness of holistic assessments based on observation compared to self-report based social care assessments. In contrast to this claim managers were concerned that occupational therapists' advocate a 'medical approach' rather than the social model of disability approach of the reablement service (Rabiee, Glendinning, Arksey *et al.*, 2009). The managers described a 'medical approach' focused on the physical ability of service users and suggested that this might lead to avoidance of risk (Newbrunner, Baxter, Chamberlain *et al.*, 2007). A possible explanation for this maybe that in two of the reablement sites the occupational therapists linked to the teams were commissioned from the National Health Service. Managers may have made assumptions that the approach of occupational therapists was in line with the predominant medical approach of acute health settings, rather than the wider holistic approach of occupational therapy. The report shares that there were differing views on the most effective staffing team for reablement. Staff from a team that employed an occupational therapist expressed positive comments about the role of the occupational therapist working with staff and providing equipment (Newbrunner, Baxter, Chamberlain *et al.*, 2007).

3.7.2.2 Goal setting and reablement plans

Goal setting is essential to reablement plans to ensure that everyone in the team is working towards the same aim with service users. Occupational therapists have training and experience of goal setting as part of the occupational therapy process of assessment, goal setting, interview and evaluation (Hagedorn, 2001). This was recognised in Edinburgh as part of the occupational therapists' role was to develop the skills and confidence of the reablement home care organisers in setting goals

for reablement support plans with service users (McLeod and Mair, 2009). Support workers in the reablement service asserted that service users “enjoyed” working towards goals (McLeod and Mair, 2009). In interviews with service users in the same study some service users were not aware that goals had been set for their period of reablement, whilst others were acutely aware and recognised that they were improving week by week. The latter group of service users may have been more motivated to participate in reablement and record their own progress.

Occupational therapists in one Local Authority developed an assessment to help define service users’ goals (Armstrong, 2001). The assessment focussed on increasing the definition of goals using descriptive statements. In an effort to capture the essence of the difficulty, words such as unable and verbal assistance were used. Descriptive words were used to define goals for intervention, such as able, pain-free, no difficulty. A pilot study reviewed case notes and reported that 73% of goals written using the new assessment were met following occupational therapy intervention. The author concluded that engaging in meaningful goals led to improvement in the health and wellbeing of service users (Armstrong, 2001). The pilot study did not include any measures of health and wellbeing to clarify this statement. The goals were used to agree on intervention. The substantial percentage of service users meeting their outcomes could demonstrate the value of setting goals to ensure that the service user and the occupational therapist are working on the same priorities; essentially taking a holistic approach, focussing on the uniqueness of the person (Finlay, 2001).

Within reablement the setting of goals personal to the service user may not be congruent with the policies of the service. During interviews with service users in the CSED study service users expressed their desire to walk outside or re-establish their social contacts in the community. Service users who lived alone with little informal support expressed issues of loneliness. Meeting goals of increased social interaction may reduce service users’ perceived need for ongoing support from statutory services, as a means of social company. In only a few cases had service users been supported to regain confidence in walking outside or meet social interaction goals; largely support was limited to meeting goals within the confines of service users’ homes (Glendinning, Jones, Baxter *et al.*, 2010).

In situations where service users are not achieving their goals during reablement, occupational therapists have undertaken further assessments to recommend alternative support, such as, a series of graded activities for support workers to undertake with service users. Occupational therapists have also discussed risk with service users who wish to undertake certain tasks, particularly if they do not wish to have ongoing support (Social Care Institute For Excellence, 2011b)

Occupational therapists contribute to reablement plans by way of occupational performance assessments of service users, provision of equipment (discussed in the following section) and recommendations for the reablement team to support service users to regain their skills. This has been shown to increase the ability of service users, reduce the support needed from formal and informal carers and thereby reduce costs. Included in a Department of Health report on occupational therapists in social care is a case study describing an occupational therapist working with a service user who had been discharged from hospital following a stroke. The service user was initially supported by two carers visiting him three times per day. Following an assessment and provision of equipment the occupational therapist set up a programme for support workers to encourage the service user to be more independent. Following completion of the programme the support workers were no longer required and the service user was able to manage with minimal supervision from his wife. This resulted in a cost saving of £271 per week (£14,109 per year) (Riley, Vincent and Whitcombe, 2008). The service user's wife was assuming the role of carer in this case. Interviews with carers have highlighted that carers want to be involved in reablement and that provision of hoists and advice about how to increase the independence of person they care for are welcome support for carers (Glendinning, Jones, Baxter *et al.*, 2010)

3.7.3 Programme theory 3 timely provision of equipment

<p>The timely provision of equipment increases the independence of service users and supports carers in their caring role.</p>
--

Box 3 Programme theory three - timely provision of equipment

3.7.3.1 Positive outcomes from the provision of equipment and adaptations

Assessment for and the provision of equipment and adaptations is a primary role for occupational therapists working in social care settings. A systematic review of the literature found that the provision of equipment increased the independence of service users, reduced falls and prevented accidents (Boniface, Mason, Macintyre *et al.*, 2013). As the provision of equipment and adaptations has clear positive benefits for service users it is perhaps no surprise that occupational therapists in reablement services also assess for and provide equipment as an element of their role (box 3). There is evidence of this provision aiding the reablement of service users (Harris, 2010; Latif, 2011; Littlechild, Bowl and Matka, 2010; McLeod and Mair, 2009)

In a review of reablement services in Local Authorities in the Yorkshire and Humber region 11 of the 15 services reviewed had access to an occupational therapist either from within the team, from the main social care team or the NHS intermediate care team (Calderdale Council and Yorkshire and Humber Joint Improvement Partnership, 2010). The review includes short case studies highlighting occupational therapists as providing small aids, such as sock aids, to assist a service user to be independent in getting dressed, as part of their reablement programme. An evaluation of the impact of occupational therapists working with service users in another reablement service included a graph of service users' functional and emotional scores, using the Nottingham person centred ladder (Latif, 2011). The graph illustrates that service users who saw an occupational therapist had higher scores, representing improved ability and more satisfaction, than service users that hadn't seen an occupational therapist. Equipment and adaptations are recorded in the report as the most prevalent type of intervention by occupational therapists, occurring in 73% of cases. Other intervention includes functional assessments, training of staff and providing advice (Latif, 2011). However the findings of this study need to be treated with caution. The report is not defensible in design. No data is included on how many service users were included in the results, and no further analysis of the scores was undertaken to confirm whether the difference in the scores was statistically significant.

In a different type of reablement service led by occupational therapists with no support workers in the team, the provision of equipment was highlighted as a key aspect to the service. Fifty two of the 57 service users evaluated, received equipment. Occupational therapists completed pre and post intervention scores using the Canadian Occupational Performance Measure (COPM). 87% of service users improved their satisfaction in the occupations they chose to work on and 55% also recorded improved performance in the same areas. These positive responses are further supported by quotes from service users during interviews, on service users' increased confidence and independence. Increased independence of service users was also highlighted as supporting carers to continue in their caring role. The timeliness of provision of equipment to reduce risks of, for example, falls on the stairs was identified as an important aspect of the service (Littlechild, Bowl and Matka, 2010).

3.7.3.2 Timeliness of provision of equipment

Prior to the CSED study of reablement, the Care Services Efficiency Delivery, published a discussion document for the development of reablement services. Information was gathered from five case studies, and thirteen Local Authorities who had implemented reablement services. Responses from Local Authorities identified that delays in occupational therapy assessments for daily living equipment could lead to some service users staying with reablement services longer than necessary. Delays in service users moving to other services, in turn prevented new service users joining the reablement service. Some services had trained managers and senior workers to assess for routine items of equipment to overcome this difficulty (Care Services Efficiency Delivery, 2007).

Timeliness of access to occupational therapists was highlighted in the main CSED study. Jones, Baxter, Curtis *et al.* (2009) provide an early report on the study focussing on the short term outcomes of the reablement services. Quantitative measures were used to assess quality of life and performance in daily activities. Service users showed improvement in performance of daily living activities using the Adult Social Care Outcomes Toolkit (ASCOT) and increased quality of life using the Health-related quality of life measure (EQ-5D), Self-Perceived Health question and a perceived quality of life 7 point Likert scale. The greatest improvement in

quality of life was seen in the sites that had timely access to occupational therapists either within the team or fast tracked from other teams. The authors highlight the caution that needs to be taken with the results of this report as a complete data set was not obtainable and the data collected was not compared with data from service services receiving standard home care. Therefore the improvement in daily living activities and quality of life cannot be confidently linked to participation in reablement or access to occupational therapists. The timeliness of occupational therapy provision was recognised as a potential context that improved quality of life of service users but no discussion of potential mechanisms that might identify why this might be the case were overt in the report.

In the second interim report of the CSED study the timeliness of support by occupational therapists was highlighted again. Interviews with managers and focus groups with reablement staff in all five case studies highlighted the role of occupational therapists in enabling quick access to equipment for service users (Rabiee, Glendinning, Arksey *et al.*, 2009). Interviews with service users and carers supported the comments of the reablement team that timely provision of equipment supported service users to meet their reablement goals. Conversely difficulties accessing occupational therapists resulted in delays in the provision of equipment, with the outcome of service users remaining dependent on the short term reablement service unnecessarily. Other reablement service staff have expressed frustration about having to wait for the provision of equipment, particularly outside of working hours (Calderdale Council and Yorkshire and Humber Joint Improvement Partnership, 2010). Service users have also raised concerns regarding the delay in the provision of equipment. A female interviewee with continence difficulties described the distress she felt in social situations as she was waiting for an adaptation to enable her to access shower facilities (Wilde and Glendinning, 2012). Timeliness of provision of equipment has been considered as the key factor for reablement services; rather than occupational therapists being members of the reablement team (Rabiee and Glendinning, 2011). This last point reinforces a narrow perceived role perceived of occupational therapists as providers of equipment and adaptations. Commissioners of reablement services may be reluctant to employ occupational therapists in the reablement teams as it would

increase the wages costs. The CSED study evaluated the costs of services and found that reablement teams with occupational therapists in the team were no more expensive than those that did not employ occupational therapists (Glendinning, Jones, Baxter *et al.*, 2010). Economic considerations do require further investigation as these findings are based on the costs of only five reablement services

3.7.3.3 Acceptability

Whilst the provision of equipment in a timely way was deemed beneficial for service users and carers in reablement services, mechanisms supporting the use of equipment in the reablement literature were not obvious from the research reports. Looking at literature on equipment provision in social care services outside of reablement, Chamberlain, Evans, Neighbour *et al.* (2001) completed an audit of service users on their use of equipment 18 months to two years after provision. From the computer generated random sample of 100 service users 51 service users and 6 carers participated in a short telephone interview. The study found that 83% of people were still using the equipment provided to them; 79% of the items were considered very useful. This suggests that the assessment for equipment was accurate and the equipment acceptable for service users, as service users were largely still using the equipment. Other service users have asserted that some equipment provided is not acceptable to them. Hocking, Murphy and Reed (2011) completed a qualitative study on the strategies that older people use to undertake day-to-day occupations. Semi structured interviews were completed with eight older people (one male and seven female, with an age range described as early 70's to 98), living in the community without an acute health condition. They were all receiving support with self-care or domestic tasks. The results should be treated with some caution as the sample were a convenience sample recruited from a church group with links to the second author. The authors identified four strategies from the interview data. Strategies to: help me be safe; recruit and accept help; meet social and biological needs; and conserve resources. The first category is the most pertinent to this study. Participants spoke of using equipment to manage risks within their environment. The participants found equipment such as rails were acceptable; whilst bathing equipment was sometimes not deemed acceptable,

particularly if it did not enable the person to do what they used to. For example a participant was given a bath seat that sat on the top of the bath but did not enable them to sit in the bath as they desired.

A large postal survey was sent to adults who had received one or more items of equipment during the 8-10 month period prior to the research (Sainty, Lambkin and Maile, 2009). From the sample of 483 people, 251 responses were received (52%). 78% of respondents reported that they were still using the equipment. Of the percentage of people not using the equipment 23% (n=8) no longer needed the equipment, 17% felt unsafe using the equipment and two people stated that they did not like the equipment. These results evidence that equipment appears acceptable to the majority of people. The report provides quotes from service users on how the equipment supported their independence for example in having a bath or going outside. The 17% of people who felt unsafe using the equipment may indicate an issue with the initial demonstration of the equipment. The article does not comment on whether initial demonstration was provided. Pressure on services may limit opportunity for staff to undertake repeated visits to ensure a service user is confident using equipment. Provision of equipment as part of a reablement service could be included on the reablement plan as a goal for support workers to work with the service user to increase his or her confidence in using equipment.

3.7.4 Programme theory 4 occupational therapists and support workers

Occupational therapists contact with support workers, including involvement in training, increases the skills of support workers and assists support workers to work in a reabling way.

Box 4 Programme theory four - occupational therapists and support workers

3.7.4.1 The role of support workers

Conversations with occupational therapists in the first stage of this synthesis highlighted that some support workers who previously worked in traditional home care services found it difficult to move from an approach of doing activities for people, to supporting people to do more for themselves. Studies of reablement services have also recognised a need for support workers to make a shift from 'doing

for' a person. A study of the development of a reablement service in the USA, known as a restorative service, reported that staff found it easier and quicker to 'do for' the person (Baker, Gottschalk, Eng *et al.*, 2001 2001). The restorative service was evaluated against the usual care service using a retrospective individual matching design. The study found that people who received the restorative service received less care and were more likely to stay at home following the period of reablement. The report identified the refocusing of the service, the identification of goals with the service user and the training of all the team members, as key characteristics of the service (Tinetti, Baker, Gallo *et al.*, 2002). During the training phase of the development of the programme support workers attended multidisciplinary training with other team colleagues. Support workers implied that their role had a low status, commenting that it was unusual for them to be invited to attend multidisciplinary training. After attending the training the support workers felt more supported by colleagues, felt recognised for their role and moved from 'doing for' the service users to what they described as '*getting patients moving*' (Baker, Gottschalk, Eng *et al.*, 2001, p.261).

Reablement managers have reported that reablement provides a challenge for some staff to stand back and not be a care deliverer (Rabiee and Glendinning, 2011). In the CSED study in some sites where support workers were transferred from an in-house home care service, staff chose to leave as they were not happy working in a different way. In contrast to this, some managers found that existing staff brought positive aspects to the service as they had an employment history in which they were well trained, motivated and eager to work with a different approach (Rabiee and Glendinning, 2011).

In all these services training appears to be a key component in the effectiveness of support workers in reablement services and has been reported as 'crucial' (Glendinning and Newbronner, 2008). It is particularly important for support workers as they are the members of the reablement team that have the most contact with service users. Typically support workers do not have a professional qualification and Bell (2001) suggests that 80% of support workers have no qualifications at all. During a qualitative evaluation of training for staff in a pilot reablement service the occupational therapists commented that all members of the

reablement team need to be confident in their level of skill. The occupational therapists expressed concern that some service users had been put at potential risk by being supported by support workers without a sufficient level of knowledge and skills to support the person (Harris, 2010). This demonstrates an instance of when the mechanism of increased knowledge and skill of support workers isn't present, leading to potentially negative outcomes for service users. These concerns are echoed by support workers in the same study who commented that they needed more training on, for example, supporting people with precautions following hip surgery to minimise risk of hip dislocation. They also wanted to be able to assess for equipment (Harris, 2010). These training needs could be addressed by an occupational therapist (box 4).

A limited number of studies have evaluated the level of training and qualifications of carers in reablement services (Bell, 2001; Nancarrow, Shuttleworth, Tongue *et al.*, 2005). Occupational therapists in studies of reablement services have expressed a desire to be involved in training of support workers, as they considered reablement as a specialism of occupational therapy (Rabiee and Glendinning, 2011). This is supported by the professional body for occupational therapists in the UK who also advocate that the skills of occupational therapists are essential for the training of support workers (College of Occupational Therapists, 2010).

3.7.4.2 Formal training of support workers

There is evidence of occupational therapists training support workers within their own teams to work in a reabling way, with a result of increased confidence of support workers (Care Services Efficiency Delivery, 2007; Le Mesurier and Cumella, 1999; McLeod and Mair, 2009). The Social Care Institute of Excellence, in their briefing about occupational therapists in reablement services, detail a case study of a five-day training programme for support workers, run by occupational therapists, physiotherapists and nurses. Topics in the programme included promoting independence, fitting equipment, normal movement, mobility, catheter care and moving and handling. The programme ensured all support workers were consistent in their reabling approach with service users (Social Care Institute For Excellence, 2011b). Occupational therapists have also trained support workers on alternative techniques, moving and handling and telecare awareness to increase the skills of

support workers and improve the quality of reablement (Latif, 2011). Latif bases his assertion that support workers increased their level of skill, on responses to a questionnaire completed by managers and support workers. However, no details of either the questionnaire or the number of respondents are given and no quotes from the responses are included in the report.

In an evaluation of a new reablement service, support workers reported that training had prepared them for their role. Occupational therapists facilitated three hours of the 13 hour training programme (McLeod and Mair, 2009). Support workers reported that they also benefitted for more informal contact with occupational therapists during weekly meetings. Support workers asserted that other members of their team valued their opinion and they had a greater sense of job satisfaction than working in their previous role as traditional home carers. One of the occupational therapists commented that working more closely with the support workers was a '*very positive way of working*' (McLeod and Mair, 2009, p.42).

A qualitative study on the impact of reablement services on the support workers who deliver the service, included the story of Zowi. Zowi was a home carer who changed her practice from 'doing things for' service users, to working in an enabling way. She reported greater job satisfaction and feeling valued as a member of the team where her input and feedback was welcomed. Focus groups held with the forty support workers included in the study identified the role of occupational therapists and physiotherapists in supporting the change in practice, stating that the therapists brought the 'science' of working in a reabling way (Chinouya and Cook, 2012).

3.7.4.3 Informal support

Lesley Bell speaks from a professional background of organisational training and development in health and social care. She asserts that support workers frequently work alone in service user's homes. Bell (2001) suggests that training for support workers needed to be undertaken in a variety of methods including shadowing and attending workshops. Occupational therapists have an important role in assessing for the most appropriate technique or equipment to use to support the service user

(Calderdale Council and Yorkshire and Humber Joint Improvement Partnership, 2010). Support workers are likely to be members of the team working regularly with service users therefore shadowing occupational therapists demonstrating techniques and equipment with service users can enable support workers to convert the knowledge gained at formal training, into practice. This 'learn by doing' approach is key to training home care workers to work in a reabling way (Barnes and Frock, 2003). Managers have reported that working alongside occupational therapists in the team enhances the skills of support workers (Newbronner, Baxter, Chamberlain *et al.*, 2007; Rabiee, Glendinning, Arksey *et al.*, 2009).

3.8 Conclusion

Local Authorities have developed a diverse range of reablement services in response to government guidance to develop prevention and enablement services in social care. The heterogeneous nature of reablement services across the UK does not provide a foundation for the certainty of occupational therapists contributing to reablement services. Whilst some research has been undertaken with reablement services, disaggregating the effectiveness of occupational therapists in the published research from the general effectiveness of the service is problematic. Theories were developed from aspects of larger research studies, opinion articles and publications from professional organisations.

The first question set for this realist synthesis concerned the role of occupational therapists in reablement services. The second question focussed on the identification of contexts and mechanisms leading to positive, or negative, outcomes for service users, carers and members of the reablement team. In answer to the first question occupational therapists complete a number of roles in reablement services. In studies to date they have been members of the reablement team or accessed via another health or social care team. The context of complexity leads to the involvement of occupational therapists in some areas, but this factor was not evident in all services. The recognition of the skills and knowledge of occupational therapists is variable across different reablement services and this is a key mechanism to how occupational therapists are utilised in practice.

In answer to both questions for this synthesis, there is evidence from reablement staff and service users that providing equipment is a role of occupational therapists that increases the occupational performance of service users and can lead to reduced care costs in the longer term. An important context is the timeliness of the provision of equipment to prevent delay in a service user becoming more independent. Occupational therapists and the professional body for occupational therapists in the UK have asserted how a broad range of occupational therapy skills could be used in reablement services. Occupational therapists appear key in formal training and informal support for support workers and this triggers the mechanism of enhanced skills and knowledge of support workers. Holistic assessment and setting goals meaningful for service users is important for reablement to meet service users' needs. The context of the policy of the service may not support meeting all goals, as such, occupational therapists may be restricted in supporting full occupational engagement for service users.

3.8.1.1 Reflection on the realist synthesis approach

A limitation of this review of the literature was the lack of published literature focusing on the role of occupational therapists in reablement services. Using a realist synthesis approach was useful to explore the contexts and mechanisms impacting on the effectiveness of occupational therapists in this area.

This realist synthesis review of the literature is the first stage of identifying programme theories associated with the role of occupational therapists in reablement services. The theories identified through the literature do not provide sufficient evidence to develop a conceptual framework for occupational therapy practice in reablement services. The theories from this synthesis will be tested and new theories sought during the second phase of the research using a case study approach observing occupational therapists in practice and seeking opinions of occupational therapists, managers and support workers through interviews and focus groups. The methodology for phase two of this project is presented in the following chapter.

4 Methodology and methods – phase 2: testing the programme theories

4.1 Introduction

Chapter two discussed the philosophical underpinnings to this study and the realist research approach. It also included the methods of phase one of this study, namely the realist synthesis review of the literature. This chapter continues with a discussion of the methodology and methods chosen for phase two of the study: the testing of the programme theories identified in phase one.

This chapter will discuss the use of a qualitative methodology, including considerations of quality in qualitative research. The chapter will continue with a discussion of the use of the case study method of Yin (2009). The data collection methods of observations, interviews and focus groups will be discussed with reflections on use of these methods. This chapter concludes with a detailed description of the case studies in this study to provide rich context for the reader when reviewing the findings of this study in the following chapter.

4.2 Qualitative approach

Realist research is considered methodologically neutral; both quantitative and qualitative methods can be used to formulate realist theory and test that theory in the field. Maxwell (2012) asserts that the ontological underpinnings of realist research fit with the features of qualitative research and that he is ‘puzzled’ that realist research hasn’t been more prominent within qualitative research. The realist synthesis review of the literature presented in the previous chapter, identified few studies evaluating the role of occupational therapists in reablement service from which to produce a programme theory to test in the study. Nevertheless the literature and consultations with the occupational therapists resulted in the initial programme theories highlighted, and provide a starting point for this study. Further information from practitioners was required to develop the programme theory. This study sought to test the limited theories identified and develop the theory further, based on the experiences and meaning of occupational therapists

and their co-workers within reablement and the contexts in which they work. With this focus the research lent itself to using a qualitative approach.

4.2.1 Qualitative research in occupational therapy

Qualitative research has been an established methodology in occupational therapy since the 1970s (Frank and Polkinghorne, 2010). A review of qualitative research published in five occupational therapy journals, geographically spread across the world over a period from 2003-2005, identified 90 publications of qualitative research (Borell, Nygård, Asaba *et al.*, 2012). Qualitative studies in occupational therapy have been criticised for remaining descriptive and lacking theoretical understanding (Borell, Nygård, Asaba *et al.*, 2012; Frank and Polkinghorne, 2010). Occupational therapists have been charged with choosing a qualitative methodology without due consideration of a particular research method to guide data collection and analysis (Finlay, 2000). Frank and Polkinghorne (2010) made several recommendations for occupational therapists engaging in qualitative research, one of which was to observe the context of the participants in the study to understand:

‘what people do, not only how they talk about what they do’.

(Frank and Polkinghorne, 2010, p.56)

The focus on context and underlying mechanisms of realist research meets this brief to interpret the data gathered and develop theories from the data.

4.3 Choosing a qualitative methodology

Phase two formed the main body of the research. The aim of this phase was to expand, test and refine the programme theory developed from the realist synthesis. There are many different approaches to qualitative research methodology (Creswell, 1998; Finlay, 2000). I considered phenomenology, ethnography and action research before choosing a multiple case study method.

Phenomenological research is underpinned by critical realist ontology and focuses on the lived experience that may have supported the identification of programme theory within the realist research approach (Creswell, 1998; Finlay, 2006a). The perspective of critical realism provided commonality with the realist research

approach of this study. Despite this, I rejected this approach due to the common feature of bracketing existing experiences of the setting (explained further in section 4.4.1 below) as this would not be possible following the identification of programme theories in phase one of this research.

I considered undertaking an ethnographic approach focusing on one reablement service. Ethnographic research focuses on the language, behaviour and interaction between different parties and typically involves prolonged observation in the field (Creswell, 1998; Finlay, 2000). The role of the researcher in ethnographic research is to immerse themselves in the lives of the people in the setting they are researching to understand the phenomenon from their perspective, as an insider. I rejected this approach for two reasons. The first is the ethnographic focus on behaviour, language and actions. My focus is on testing theories from the literature both through observation of actions and through realist interviews with specific members of the team. The second reason refers to ethnographic research typically involving prolonged observation in one setting. Whilst an ethnographic approach may support identifying new mechanisms, contexts and outcomes, working within one setting would limit the opportunity to confirm or dispute the theories identified from the literature as reablement services are not homogenous in their set up and delivery.

I also considered an action research approach. Action research involves the researcher situating themselves within a setting with the aim of improving the situation. Health and social care are recognised as settings undergoing constant change and action research has been utilised within these settings in the form of practitioner researchers (Freshwater, 2005). I have a professional qualification as an occupational therapist and may have been able to find a position as an employee, or worked voluntarily, as an occupational therapist in a reablement service. This would have enabled me to experience working within a reablement service and would have given access to other therapists and members of the team over a significant period of time. However, I was not able to undertake this route due to pragmatic reasons. I am a part time researcher and a part time employee. I was not able to work in a reablement service for a prolonged period of time. Additionally, as in previous approaches considered, I would only be studying one

reablement service. Due to heterogeneous nature of reablement services I felt a case study methodology would enable me to study reablement in a number of settings to establish commonalities and differences across the settings.

4.3.1 Case study methodology

Case studies have been identified as a credible approach to test theory, as phenomena can be studied in detail and different aspects confirmed with participants (George and Bennett, 2005). Researchers can use documents and conversations to immerse themselves in the case a process described as 'soaking and poking' (George and Bennett, 2005, p.89). Including a number of cases in the study can enable comparison between cases. This research focussed on reablement services that consist of two organisations, as there has been limited research on reablement in these type of services. Restricting my study to reablement services made up of two organisations enabled comparisons to be made between the case studies.

Two case study methods were considered for use with this study. Case studies are described as an approach in qualitative research by some authors and as a methodology in its own right by others (Creswell, 1998; Stake, 1995; Yin, 2009). Stake's (1995) case study method has a strong focus on observation of specific and complex cases. His case studies are presented with a detailed narrative of complex situations with a strong emphasis on the interaction between different characters, requiring prolonged contact in the field. This case study method was not chosen as this study seeks to explore the practice of occupational therapists working in reablement services from a number of different perspectives. Occupational therapists in reablement services, as in other community settings, work with individual service users and carers in their own homes for short periods. The emphasis of the case study is not a detailed narrative of interaction between a few people, but similarities and differences in practice between occupational therapists and reablement services. In light of this emphasis shorter observations of several occupational therapists within each case study setting was considered as potentially more effective in confirming or disputing the programme theories from the realist synthesis and identifying any new theories.

This study utilises the multiple case study method described by Robert Yin (2009). Yin asserts the need to study the context behind a phenomenon, suggesting that case studies benefit from data collection being guided by theoretical propositions developed prior to gathering data. This method fits with the realist approach to the study. The programme theory from the realist synthesis form the theoretical propositions. Yin's method was also chosen as the literature on this method includes comprehensive guidance for the different stages of the case study and the role of the researcher; that was used to guide this research.

Three case studies were chosen for inclusion in this research. The research methods included observations of occupational therapists in practice, interviews with occupational therapists, their managers and managers from the independent agencies; and focus groups with support workers. Information on the reablement service was also gathered from literature available in each setting. Prior to describing the recruitment of case studies, participants and the methods used, the following section considers the aspect of quality in qualitative research.

4.4 Quality in qualitative research

Occupational therapists are required to engage in evidence based practice, grounding their practice on robust evidence (Health and Care Professions Council, 2013b; Seale and Barnard, 1998). The concept of robust evidence and how we evaluate research has been widely debated (Boaz and Ashby, 2003; Cutcliffe and McKenna, 1999; Lincoln and Guba, 1985; O'Dwyer and Bernauer, 2014; Seale and Barnard, 1998). Quantitative research, following the philosophical underpinnings of positivism, seeks valid causal inference; that justifiable conclusions can be made from the research design used (Vogt, 2011). The quality of quantitative research is evaluated by its reliability, validity and generalisability (Finlay, 2006b; Seale and Barnard, 1998). In essence, were the research methods used reliable in their measurement? Were they a suitable measurement for the topic concerned? and can the results be generalised to other settings?

Qualitative research, in contrast to quantitative research, focuses on understanding a situation from the perspective of the participants within it. Qualitative researchers have argued that evaluation criteria for quantitative research is not

appropriate for evaluating qualitative research (Kreftling, 1991). Early evaluation criteria for qualitative research mirrored the quantitative criteria of reliability, validity and generalisability with the terms dependability, credibility, confirmability and transferability (Lincoln and Guba, 1985). These terms sought to address the notion of readers being confident in the findings of qualitative research (credibility), demonstrating that the findings could be repeated (dependability) and that issues of researcher bias were minimised (confirmability). These criteria have continued to be used by researchers, journal reviewers and funders to evaluate qualitative research, including multiple case study research (Houghton, Casey, Shaw *et al.*, 2013; Morse, 2015). Strategies to establish the 'trustworthiness' of the study (as a replacement for the word rigour) using Lincoln and Guba's (1985) criteria are documented and include prolonged experience in the setting, triangulation, member checking, dense description, audit trail, peer examination and reflexivity (Kreftling, 1991).

Assessing rigour at all, has been asserted as incongruent to the flexible approach of qualitative research (Baillie, 2015). However, consideration of the quality of qualitative research is necessary to establish the robustness of the research in line with the approach of evidence based practice, as Creswell (1998) states:

'How do we know that the qualitative study is believable, accurate and 'right'?' (Creswell, 1998, p.193)

Echoing the evaluation aspects of the realist synthesis, in the previous chapter, qualitative research needs to demonstrate rigour in its process and relevance in its output (Finlay, 2006b). Reablement is commissioned by public bodies either Local Authorities or community health services, or both. As such, reablement is subject to the policy of those organisations. Boaz and Ashby (2003) argue that in assessment of the quality of research in areas such as reablement, there should be a focus on 'fitness for purpose' so policy makers can relate the findings to their service. They propose four dimensions of research quality:

- Appropriateness of the methods
- Methodological quality

- Quality and transparency in reporting
- Relevance to policy and practice

These four topics encompass the evaluation criteria previously discussed: credibility, dependability, confirmability, transferability. In evaluating qualitative research it is important for authors to demonstrate how the research was undertaken and with what methods, considering the influence of the researcher and the key messages for policy and practice. This chapter serves to demonstrate the methodological quality of this study, the appropriateness of the methods and provide transparency in reporting; essentially the criteria of confirmability and dependability. The discussion chapter and conclusion serve to demonstrate the relevance of this study to policy and practice.

It is suggested that researchers outline the strategies they used to endorse the credibility of their research (Cutcliffe and McKenna, 1999). Methods used to demonstrate rigour in this study include ethical approval, triangulation of data, member checking, dense description of the research process and the research settings, and reflexivity. These methods will be described in the relevant sections describing the methods in this chapter. With particular reference to transparency in reporting, and the specific criteria of confirmability, the following section considers my engagement in reflexivity and provides details about my identity as the researcher.

4.4.1 Reflexivity

Reflexivity describes the researcher's awareness of their subjective responses on the research (Finlay, 1998). Authors differ in their description of the aspects of reflexivity and when it should occur and this has contributed to a poor understanding and use of reflexivity by researchers (Darawsheh, 2014). Using a qualitative case study design my aim was to describe and analyse the role of occupational therapists in reablement services as told by occupational therapists, support workers and managers within reablement services. References to empirical data such as observations, interviews and focus groups, are the result of interpretation (Kreftling, 1991). These interpretations and theoretical assumptions are not neutral, they are affected by the impact of position, perspective and

presence of the researcher. For information for the reader I am a researcher who is also an occupational therapist. I work for a Local Authority adult social care department, not in a reablement service. I have worked as an occupational therapist for over 15 years and have a Master of Science degree in occupational therapy practice. I am female, white British in my early forties.

My role as an occupational therapist involves observation skills, assessing service users' abilities and interpreting them. My working role creates a lens through which I am interpreting the data gathered. To manage the influence of the researcher two reflexive methods are proposed: bracketing your experience, an act of separating your experience and preconceptions from the research process; and self-awareness, being aware of your experience, recognise any bias and be transparent concerning the influence of experience on the research (Darawsheh, 2014).

Bracketing has origins in phenomenology (Gearing, 2004). In realist research, the setting aside of existing presuppositions of, in my case, reablement in brackets is limited. Realist research begins with programme theories developed from the literature and the data collection phase seeks to confirm or dispute these theories. In this way it is not possible to bracket this knowledge, as data collection is dependent upon it. As the sole researcher in this study, I was the data gatherer, analyser and reporter; making me a tool through which the study took place. Research was 'co-constituted' between myself the participants and the relationship between us (Finlay, 2002b).

As an alternative to bracketing my knowledge and experience I engaged in intersubjective reflection, actively exploring the nature of the relationship between myself and my participants (Finlay, 2002a), in the design, data collection and data analysis stages of my study. In the design stage I reflected on whether to disclose the information that I am an occupational therapist to my participants. Early in the design of my research I read the article 'the doctor or the girl from the university' (Richards and Emslie, 2000), which reveals how people respond differently depending on how the researcher presents themselves either as a professional researching a topic or as a researcher (without disclosing professional background). In Richard and Emslie's (2000) study two researchers carried out

similar research on heart disease with a similar client group. One research introduced herself as a GP undertaking research and found that participants shared detailed information about their health problems, asked for advice and generally spoke positively about GPs. The second researcher was a sociologist with a doctorate who described herself to participants as a researcher. Her participants did not share any health problems with the researcher and expressed concern about GPs, for example, not listening to them. I reflected that my participants were primarily occupational therapists. Therefore unlike Richard and Emslie's (2000) study the participants were in the similar role as myself. However, I would need to be aware of the impact of my role on the research. In keeping a reflective journal I sought for transparency in my research. The journal also provided an element of the audit trail of the research process.

I decided that in order to demonstrate integrity in my research that I would include my role as a part time occupational therapist and a part PhD student on my information leaflets. I introduced myself first as a research student and then as an occupational therapist. This did produce some situations that wouldn't have occurred if I had presented myself only as a research student. For example, on some occasions service users and carers asked me questions about their particular situation. Comments such as '*what do you think?*' or '*have you come across this before?*' were asked. In these cases I may have been seen as the 'professional expert' by the service user (Conneeley, 2002). I reflected in my reflexive journal on how to deal with these questions. This is an excerpt from my journal:

I was asked my opinion by a service user during a visit today. I had an answer and it is natural for me to answer in my usual work role. It was more difficult for me to not answer straight away. I was aware that my answer may not have been the same as the occupational therapist I was observing. After the occupational therapist spoke I answered the service user's direct question politely advising that my role was to observe the occupational therapist and what she thought. The service user appeared to accept this.

During data analysis I utilised my reflexive diary to highlight areas I might influence the analysis by my experience. As a started my analysis I actively reviewed whether my initial thoughts were based on the data or were influenced by my role as an

occupational therapists. An example of this included the reduction of support with moving and handling from two carers to one. This has been an aspect of my own work practice and was identified as a role of occupational therapists in this study. I wrote a section in my reflexive journal on my feelings about this practice in reducing support and the associated cost to ensure I was aware of my potential bias. As I analysed data I continually checked that my analysis was centred on the interview participants' description and thoughts about moving and handling, rather than my preconceptions, by ensuring my analysis was evidenced in the coded sections of transcripts on that topic.

4.5 Selecting case studies

This study included three case study sites of reablement services to gain a breadth of data from services delivered from different organisations. The focus of this study is the role of occupational therapists in reablement services. The first criterion for inclusion as a case study area were that the reablement service had occupational therapists working within the reablement team.

Chapter one included a discussion of the current provision of reablement services. At the commencement of this study began almost 25 per cent of reablement services involved a second organisation. These organisations are commissioned as a result of outsourcing, or externally commissioning an element of the service from the Local Authority. A survey of commissioning practice highlighted the use of short term contracts due to lack of trust between Local Authorities and domiciliary care agencies, affecting the ability to form longer term relationships (Rubery, Grimshaw and Hebson, 2013). The second organisation is usually a domiciliary care agency who provide reablement support workers. I was interested in the relationships between occupational therapists and support workers when they work for different organisations. There is a paucity of research of reablement services involving two separate organisations. The second criterion was that a second independent organisation was part of the reablement service.

The final criterion for inclusion as a case study was a pragmatic one. As a part time PhD student with a part time job locally I made a decision to only include reablement services within a two hour drive from my home.

4.5.1 Recruitment of case studies

The first recruitment method was by purposive sampling. Purposive sampling is a non-random method of selecting cases, by the researcher, that will be particularly informative to the objective of the study (Neuman, 2014). My request sent via the Social Care Network of the Royal College of Occupational Therapists, described in chapter two, invited people to participate in my study if they met the above criteria. I received five responses from services that met my criteria from all parts of the United Kingdom. Two of five responses met my criterion of being located within a two hour drive from my home and they were in the South/South West of England. Pilkington (2013) produced a report to the, now disbanded, Care Services Efficiency Delivery (a programme of the Department of Health) listing details of the reablement services in all Local Authorities in England. The report contained information on all reablement services in England and whether they had outsourced any of the service. A review of the report identified potential Local Authorities that met my criteria. I approached these Local Authorities to participate in my research and my third case study was recruited by this method.

4.5.2 Description of the case studies

Each of the case studies selected represents one reablement service as a whole. In all cases this included two organisations. One organisation being the Local Authority social care department or Local Authority social care and health combined department and the other being an independent organisation. All the occupational therapists were employed either by the Local Authority, or the Local Authority and health organisation. The independent organisations employed the majority of the support workers who worked with the service users.

In each of the organisations there was a variety of names for users of the service including customers, clients and patients. The different words used represented the custom of each setting. The word patients was used in the setting that was an integrated health and social care service where the therapists in the team had previously been part of a National Health Service (NHS). There were no significant noticeable differences between users of the service in each of the case study areas. Therefore the word service user is used consistently throughout this thesis to represent users of the service; to provide consistency for the reader.

Similarly members of staff that undertook reablement programmes with service users had different titles in different services including reablement therapy workers, regaining independence assistants and reablement support workers. The title was dictated by the reablement service and often included terminology from the name of the service. For consistency these staff are called support workers throughout this thesis. A comprehensive description of the context of each case study is presented below, section 4.11.

4.6 Ethics

The study was approved by the University of the West of England's faculty research ethics committee. The Social Care Research Ethics Committee initially suggested that I did not need to apply for my research to be considered by their committee as my research primarily involved speaking to staff about their practice and no service users were to be interviewed. However as service users were to be visited whilst I was observing occupational therapists in practice, I decided to make an application to the Social Care Research Ethics Committee to ensure the plan for my study had considered ethical aspects in its broadest sense. Applying to the Social Care Research Ethics Committee enabled my study to be considered by the wide range of people on the ethical committee including service users, carers, health and social care professionals and academics. The Social Care Research Ethics Committee provided useful feedback on the wording of my information leaflets and consent forms and suggestions regarding feedback on observations to service users. Following some amended documentation the Social Care Research Ethics Committee approved the study (see letters in Appendices H and I).

4.6.1 Permission from each case study area

This study involved reablement services commissioned either solely by Local Authority social care services or by joint health and social care services. At the time of this study there was not a standard system for the ethical review of social care research across different Local Authorities. The Department of Health Research Governance Framework for health and Social Care (Department of Health, 2001) asserted that social care organisations should each consider research projects and

make a decision as to whether they give permission for that study to go ahead in their organisation or not.

Each Local Authority or joint Health and Social Care Service supplied their research governance procedures under the Research Governance Framework. An application for ethical consideration was completed for each case study area and permission to undertake research was given.

4.6.2 Main ethical issues

As a qualitative study seeking to explore the practice of occupational therapists, my research did not include discussing particularly sensitive or personal topics. It did not include any examinations or experiments and therefore ethical issues concerning harm to participants were minimised. However, it is important to consider the safety and emotional impact of a qualitative study on its participants. The main ethical issues identified in this research were the risk of participants feeling coerced to participate in the research, visiting service users in their own homes, the emotional impact of being interviewed and ensuring the confidentiality of information. These main issues will be discussed in turn.

4.6.2.1 Risk of coercion

The first risk identified was of participants feeling coerced into taking part in the study if they were approached to do so by their manager, due to potential power relationships between employees and managers. Following the granting of permission to carry out research from the case study organisation, where possible, I attended a staff meeting to explain my research project. I handed out information leaflets and consent forms and answered any questions at the meeting. I then asked for people to consider being in the study and return a consent form to me in the post if they wished to participate. Once a consent form was received I telephoned the potential participant to confirm that they had volunteered to participate and arranged my first observation visit. All occupational therapists advised that they had volunteered to participate.

This method of introducing my studies at meetings was successful in recruiting occupational therapists and some managers. It was not possible to meet support

workers to recruit them to participate in focus groups in this way due to the frequency and attendance at meetings. If it was not possible to attend a staff meeting my alternative option to reduce the risk of coercion was to ask for a list of names of all potential participants and give information leaflets with consent forms to participants in named envelopes via the organisation. Managers of support workers did not agree to this method. Managers invited me to their offices on a day of their choice when support workers were present. Prior to each focus group I outlined that participation was voluntary and participants could withdraw at any time without reason. Each participant agreed to participate in the study.

4.6.2.2 Visiting service users and carers at home.

The study involved observing occupational therapists carrying out their role. This included home visits to service users. Occupational therapists were asked to seek permission from service users for me to accompany the occupational therapist on their visit. At the beginning of each visit I confirmed to the service user that they agreed to me being present. I confirmed that the service they received would not be affected by my presence. After explaining the content of the information letter and consent form every service user agreed to my presence. I was already in the service users' home when I described the study and service users may have felt pressured to agree to participate. Therefore I also observed the language and behaviour of the service user. Service users frequently commented about other research they had been involved in or expressed positively the role of everyone in the reablement service as people trying to help them. Service users spoke openly during my visits and did not appear distressed at any time.

4.6.2.3 Emotional impact of being interviewed

Being interviewed can have an emotional impact on participants. Staff working in reablement services are working with people who may be physically or mentally unwell. These can be situations that staff relate to in their own lives and talking about them could be upsetting. Occupational therapists, managers and support workers all read information leaflets prior to agreeing to participate in the study. The information leaflet clearly stated a disadvantage in taking part of the study as follows:

What are the possible disadvantages of taking part?

Having your answers to questions about your role in the reablement service recorded may feel quite intrusive. You should only agree to participate if you not worried about having your opinion recorded.

Participants were advised that they did not have to answer any question they did not wish to answer. No participants became visibly upset during interviews or focus groups. On the contrary one participant stated that they found the interview therapeutic, she said she felt she had '*got it all off my chest*' another participant stated that she appreciated the '*chance to reflect*' on her work following a visit to a service user. A qualitative interview being perceived as therapeutic by the participant has been identified in other studies (Richards and Emslie, 2000).

4.6.2.4 Confidentiality of data

My information leaflets addressed issues of anonymity and confidentiality and confirmed that participating in the research was voluntary and in the case of service users, would not affect the service they received from the reablement team. Participants were provided with details of my Director of Studies to contact if they have any concerns and were advised in the leaflet, and when I first met them, that they could withdraw from the study at any time.

As a part time student I am based at home rather than at the University, the Social Care Research Ethics Committee raised the topic of storage of information. All identifiable data such as emails and first transcripts of interviews were stored on the network drive of the University that I could access from home using a login and password. Paperwork such as consent forms with personal data recorded were held in a locked cabinet in my home for the duration of my study and then held at a secure storage facility at my workplace for the six years required by the University. Data was only analysed once identifiable names, places and organisations were changed.

4.7 Recruitment of individual participants

4.7.1 Occupational therapists and managers of the Service

For two of my case studies I was able to visit the occupational therapy team to discuss my research, provide information leaflets about my study and answer any questions. As described above, attendees were given an information leaflet and asked to sign and return a consent form by post if they wished to participate. Participants returned signed consent forms by post, following my visit. A visit was not possible in the third case study area. The manager of the service forwarded an email invite to participate in the study to occupational therapists in the team. One occupational therapist volunteered to participate in the study from this contact. Two further occupational therapists were recruited via a senior occupational therapist making a second request for volunteers. All occupational therapists signed a consent form and expressed that they were volunteering to participate.

My initial contact with each of the case study areas was with the manager. These managers were approached to participate in an interview as part of the study. Some managers participated themselves and some directed me to another manager who they judged to have more experience or knowledge of the current reablement service in their area.

4.7.1.1 Support workers

In all cases I contacted the managers to recruit support workers to my study. My first intended approach of attending a staff meeting to describe my study was not possible with support workers. My second method of sending information leaflets and consent forms in named envelopes as discussed in the ethics section was also unsuccessful. Managers were reluctant to provide names of workers. In the case study named Averdale support workers were employed both by the health and social care side of the service and the independent organisation. I was able to personally invite support workers employed by the health and social care organisation to participate in my study when I saw them in the office. The focus group that followed was arranged by the coordinator who arranged the support workers' visit schedule.

In Averdale the manager of the independent organisation stated her preference to arrange a meeting for me to meet the support workers and ask for volunteers on the day to participate in the focus group. Managers reasoned that the support workers do not meet as a group often and they would need to fit participating in a focus group around their visits to service users. As support workers were being asked consider being in the study 'on the spot' I discussed the consent form with participants without the manager present to ensure they were agreeing to be in the study, before the focus group started. Similarly in case study Foybrook the manager sent a request for volunteers to the support workers. I was invited to visit the office for the day. I interviewed the manager of the service. Due to pressure of work, support workers were only able to attend the office between visits to service users. To accommodate this individual interviews were held with two support workers and four more support workers were interviewed in pairs.

No staff from the independent organisation in case study Tollbury were included in the study. Following initial agreement to participate in the study the original manager left the company. Despite several telephone calls, emails and a letter to the organisation I was unable to gain permission to interview the manager or undertake any focus groups with support workers. Whilst I was not able to speak directly to the support workers in a focus group, during an observation of an occupational therapist I attended a review meeting at the independent organisation where service users' progress was discussed. Attendees at the meeting included the occupational therapist, the manager of the independent organisation and nine support workers. This meeting provided useful insight into the views of the support workers in relation to service users, and the relationship between the support workers and the occupational therapist.

4.7.1.2 Service users

During the planning phase of this study I considered including service users as participants in the study. However, an initial conversation with the first organisation approached to participate in the research confirmed that the organisation would not agree to service users being included in the study. The manager reasoned that the service users were an over-researched group due to a number of evaluations that had taken place with service users during the early

development of the service. It could be argued that as reablement is typically a short term service, service users who were interviewed previously would be unlikely to still be in contact with the reablement service and, as such, potential participants in this study. Despite this, service users could not be approached in that area. I considered approaching a service user group to understand their experience of working with occupational therapists in reablement services. There was not an existing service user group specific to reablement in any of the case studies. I considered approaching other service user groups. However, occupational therapists work in a both hospital and community settings. Interviewing service users who had experienced both acute services and received support at home, it would be challenging to confirm that all comments about occupational therapists related to experience in a reablement setting. This was key to refute or confirm the programme theory of the realist study. Service users were indirectly included in the study as I was able to observe the interaction between service users and occupational therapists during home visits with occupational therapists.

All the occupational therapists visited service users and carers in their own homes during my observation of their practice. The occupational therapists were asked to provide information leaflets and consent forms to service users to explain my study prior to the first visits. In practice, occupational therapists asked the service users for permission for me to be present during the occupational therapy visit usually by telephone prior to the visit. As this became evident I asked the occupational therapists, as far as they were able to, to not arrange to visit service users where there was reason to doubt that they did not have the mental capacity to consent to being observed as part of my study, as informed consent would be difficult to determine. At each visit to a new service user I explained the nature of my study to the service user at the start of the visit, provided an information leaflet for the service user to read and asked them to sign a consent form. No service users or carers declined to be observed.

On one occasion we visited a service user with dementia where there was reason to doubt that she had the mental capacity to decide to be included in the study or not. As an occupational therapist I am trained in completing Mental Capacity Act assessments. In talking to the service user I assessed that she was unable to

comprehend what I was explaining to her and unable to retain any information long enough to make a decision to participate. I concluded that she did not have the mental capacity to decide on whether to participate in the study. On this occasion her son was present who explained that when first diagnosed with dementia his mother was interested in research and had participated in a study about dementia. The visit focussed on a conversation with the son rather than any intervention with the service user. So consent was gained from the son to participate in the study.

4.8 Participants in the study

A total of 31 participants were included in the study (see table 6). Names of case studies and participants are pseudonyms.

Case study	Local Authority and/or health participants				Independent organisation participants	
	Occupational Therapy Staff	Years as an occupational therapist	Years in reablement	Manager	Support workers	Manager
Tollbury	Gill	4	4	Martin	0	0
	Clare	1	1			
	Pete	4	2			
Foybrook	Angela	11	1	June	Flynn Ella Molly Olivia Joy John	Maisie
	Grace	20	2			
	Chloe	27	2			
Averdale	Barb	2	1	Emily	Wendy Stella Sandra Liz A Paula Liz B Rosie Matt Suzy Melanie	Carolyn
	Jane	2	<1			
	Zoe	5	<1			
	Hannah	4	3			
Totals	10			3	16	2

Table 6 Participants in the study

Nine occupational therapists and one occupational therapy assistant were included in the study. The occupational therapy assistant was undertaking a part time degree in occupational therapy. To maintain confidentiality and for continuity the occupational therapy assistant is described as an occupational therapist throughout the study. Occupational therapists had been qualified for between one and 27 years and had worked in a reablement setting from less than a year to four years.

4.9 Data collection

Yin (2009) suggests that case studies should include multiple sources of evidence to answer the descriptive and explanatory question of what is the current role of occupational therapists working in reablement services. Seeking data from multiple sources can enable a triangulation of data. Triangulation is the use of multiple sources of data to increasing the confidence in the findings (Baillie, 2015). For example, one of the programme theories of this study concerned the provision of equipment and adaptations. Observation of home visits provided additional evidence on the assessment for equipment and the impact of having equipment for service users and carers. Observing occupational therapists prior to his or her interview enabled me to confirm details and understanding regarding situations I had seen. Occupational therapists were encouraged to discuss examples of people we had visited in their responses. Information from reablement managers and support workers was used to triangulate information from occupational therapists as well as identify additional elements of programme theory.

4.9.1 Observations and documentation

Each occupational therapist in the study was observed in practice for up to two days. The aim of this observation period was to gain an understanding of the reablement setting, the wider team and the occupational therapists' role within the team. I assumed a non-participatory approach. Undertaking observations is seen as a way to increase the credibility of the study through 'prolonged engagement and persistent observation' of the setting (Lincoln and Guba, 1985). Observation over a period aims to establish trust with the participants leading to more information being shared (Morse, 2015). The period of observation was not intended to continue until no new themes emerged and data was considered

saturated, as in other case study research (Houghton, Casey, Shaw *et al.*, 2013). In keeping with the realist research approach observations were undertaken to seek evidence to confirm or refute the programme theories identified from the literature, and identify new theories. In this way, observations were an aspect of the triangulation of the data.

4.9.1.1 Observations undertaken

Each of the occupational therapists was observed for a duration ranging from 3 hours to two days (median average 1 ½ days). Occupational therapists were observed for a total duration of 12 days resulting in 43 A4 pages of typed notes. Observations of occupational therapists working directly with service users primarily involved home visits (n=20) with one assessment completed on a hospital ward. Each visit involved a different service user, a total of 21 service users. It was not possible to meet the same service user on two occasions due to the short duration of observation time with each occupational therapist.

Observations included observing occupational therapists in the office recording visits and assessments on the computer, discussing cases with colleagues and speaking to other agencies about the services users on their caseload. Observations also included observing an occupational therapist delivering a training session on the reablement service to other staff and an informal visit to the independent organisation providing the support workers for the reablement service. Three meetings to review and discuss the progress of service users in the reablement service were also observed. Attendance at this meeting included a mixture of support workers, the independent organisation coordinator, occupational therapists, physiotherapists and a social care worker from the longer term team.

Each case study provided documentation on their service including leaflets for service users on their reablement service, copies of assessments and reablement plans, information on reablement eligibility and process documentation written for staff.

4.9.2 Reflection on observations note taking

I have previous experience in interviewing people as part of a qualitative research project. However, my experience of observations in any formal way is exclusively

related to assessing service users as an occupational therapist. This led to two different entries in my reflective journal. The first was about my lack of experience in observation in particular how to take notes of observations. To increase my awareness of aspects of observation in research I read the work of Emerson, Fretz and Shaw (2011) that describes taking 'headnotes' or mental notes of situations to be written up later as the focus is on the researcher immersing themselves in the situation. They also discuss writing field notes including first impressions and significant events. As I was new to observing people in a research setting I was not confident that I would be able to take 'head notes' to write up later and had a notebook to write notes when observing occupational therapists. I explained to the occupational therapists and service users we visited that I would be taking notes.

During my first observations I recognised that it was natural for me to slip into an assessor mode. One of my early observations at a visit read.

The occupational therapist asked about mobility around the home. Mrs X said she is managing with the stairs.....

I reflected that I was experienced in writing factual reports on occupational performance as an occupational therapist. I needed to de-familiarise the situation of a home visit, to see it as 'data' in my research. In future observations whilst writing some factual information for context I focussed on the occupational therapists' interaction with service users, language and explanation of the service as this detail related to my programme theory. I looked for evidence to support or refute my theory such as the use of equipment and adaptations to support service users. In almost all cases I observed occupational therapists for a whole day. Using this approach I was able to discuss visits we attended together after the visit to ensure that I recorded the occupational therapist's perception of the visit and the service user; rather than my own interpretation.

4.9.3 Interviews

Interviews were held with occupational therapists and managers. Ten occupational therapists were interviewed. Interviews with occupational therapists ranged from 25-57 minutes in length with an average duration of 44 minutes. Interviews were semi structured in nature with questions linking to elements of the programme

theory. Wider questions on participants' experience and views of working in a reablement service were included to identify additional mechanisms and concepts affecting the outcome of reablement. Each occupational therapist was asked in advance to think of an example of their work with a service user that had gone well. The 'mini case studies' shared are included within different sections of the following chapter to illustrate different findings.

Interviews were approached using the realist teacher-learner interview method (Pawson and Tilley, 1997). Questions are asked based on the programme theory generated from the literature. The researcher is in effect explaining some of the theory for the participant to 'learn' and respond to the question. An example of this was the question:

Other people have identified that obtaining equipment in a timely way is important, what are your thoughts about that?

The participant's response then refines the theory. Examples of interview schedules for interviews with occupational therapists and managers are provided in Appendix J

Interviews were held with five managers covering each of the reablement services to understand their experiences and views on working with occupational therapists. Three were managers of the Local Authority or integrated health and Local Authority service and two were managers in the independent organisations. Interviews ranged from 17 to 27 minutes with an average duration of 22 minutes. The duration of each of these interviews is recognised as fairly short. Managers were limited in the time they were able to give for interviews. Answers to questions were succinct providing details of the development of the service. Managers were asked about the skills and experience they would look for in employing occupational therapists and were able to provide a list of attributes. Answers were typically brief to questions on training, influence of policy and future development of the service. Managers generally responded positively regarding the relationship between the two organisations of the reablement service, otherwise they responded that it was a 'work in progress'. Managers provided what could be categorised as a corporate response. The short interview length can also be attributed to the lack

of relationship with the manager; the interview was a one-off event. In contrast to the interviews with occupational therapists where interview questions grew from observations of practice to clarify details.

4.9.4 Focus groups

Focus groups were chosen as a group interview method for support workers. Sixteen support workers were included in the study with data collected via two focus groups, two joint interviews and two individual interviews. A focus group schedule is included in Appendix K. Focus groups and interviews ranged from 12-39 minutes with an average duration of 27 minutes.

Focus groups were chosen as the support workers all have the same role in the reablement service and focus groups assist in understanding attitudes to a phenomenon (Seale and Barnard, 1998). One carer's answer to a discussion topic can be built on by other participants in the group and similarities and differences in their views of reablement and working with occupational therapists can be explored. Focus groups have been identified as a useful tool for occupational therapists to use to explain phenomena from different sources. Hollis, Openshaw and Goble (2002) suggest four aspects to enable good interaction in focus groups. The first aspect is key informants. Focus groups only involved support workers, the people working with occupational therapist to undertake reablement in the community. The second aspect is questions. Questions sought to probe the views of support workers on their role and their interaction with occupational therapists, based on aspects of the programme theory. The realist approach of a teacher-learner interview (Pawson and Tilley, 1997) was undertaken as in the interviews with occupational therapists. An example statement was:

Occupational therapists have described themselves as client centred assessing people's difficulties and focussing on the priorities of the service user, would you agree with this statement?

Open questions were asked on what support workers understood about occupational therapy and how they worked with occupational therapists to identify any new mechanism and contexts not identified in the programme theory.

The third aspect described by Hollis, Openshaw and Goble (2002) is ambience; the setting. Focus groups were held in meeting rooms with only support workers present. The focus group started with a welcome and an outline of my role and the research study. Participants were invited to contribute anything they wished and reassured that their responses would not be shared with their manager unless I was legally obliged to do so, for example if harm was identified. Participants were asked to respect each other's views if they did not agree with them. The welcome sought to encourage all participants to participate. A weakness of focus groups is the potential for participants to agree with each other and give tailored responses in line with their colleagues. During focus groups participants agreed and disagreed with each other's comments demonstrating independence in responses and consideration of the topic. This interaction between participants sets focus groups apart from group interviews (Kitzinger, 1994).

The fourth aspect is the facilitator. I am experienced in facilitating groups in a therapeutic and a learning environment. This experience was beneficial in running focus groups. I attempted to engage all participants with encouraging words to continue. Some participants were less vocal than others, as an experienced facilitator I was aware of ensuring that all voices were heard.

4.9.5 Member checking

Member checking refers to sending interview transcripts, or analysis, to participants in the study to check for accuracy. All interview and focus group transcripts were emailed to participants to check. Whilst observing occupational therapists working with service users I offered to send service users my observation notes. Several service users asked to see the notes. I discussed with my Director of Studies whether to send my factual notes of the meeting or my factual account and my reflections, questions and thoughts. My reflections and questions were often based on my programme theory and linked to previous visits or interviews. As this information would not be entirely related to each particular service user I opted to send the factual account of the visit to service users.

Morse (2015) questions the purpose of member checking, suggesting that participants should not be given an opportunity to 'change his or her mind' through

reading the transcript. In this study a transcript was returned from a manager with a correction of an error she had made with regards to a process she had described. This was helpful in confirming her data with other sources.

4.10 Data analysis

Data analysis was undertaken following guidance on analysis of qualitative research using a realist approach and analysis of case study data using explanation building (Yin, 2009).

Similarity and contiguity have been asserted as two important aspects to consider in the analysis of qualitative data in realist research. Similarity relationships are described as virtual relationships based on commonalities or resemblance alone. Contiguity relationships in comparison have a real connection in time and space not just similarity. (Maxwell, 2012). Based on the concepts of similarity and contiguity Maxwell (2012) outlines two analytical strategies: categorising and connecting. Categorising strategies are perhaps the most familiar method of analysing qualitative data. Categorising data involves breaking down data into themes or codes. It enables the researcher to order the data into themes or categories based on similarities. The categories may then be linked into larger patterns or theories. Maxwell (2012) suggests that this final linking or connecting categories is based on similarities and the contiguity of the data is lost. To address contiguity, analytical strategies in the connecting category include profiles, narratives or case studies. Whilst narratives and case studies retain the context of the data, important for realist research, using connecting strategies alone does not allow for comparison of one case study with another for similarities and differences. The use of case studies in this research supports the connecting strategies. Section 4.11 provides a profile of each case study prior to a presentation of the analysis of the data using categorising strategies in the following chapter. This supports the connection to the contexts of each case study.

The data analysis strategy used in this study is known as relying on theoretical propositions; using the analytical technique of explanation building. These methods are suggested by Yin (2009), my chosen case study methodology, and complement the realist approach and categorising strategies of Maxwell (2012).

4.10.1 Relying on theoretical propositions

Relying on theoretical propositions is a core analytical strategy method of analysing case study data. This involves returning to the original research questions, literature and propositions made (Yin, 2009). The programme theory developed in the realist synthesis review of the literature presents the propositions that guided data collection and data analysis. The aim of analysis in this research was to confirm or refute the propositions of the programme theory and identify new elements of programme theory.

4.10.2 Explanation building

Yin (2009) asserts that pattern matching is the preferred technique for analysing case study data. This technique compares data gathered from case studies with the propositions of the study. This technique was considered for this study as the programme theory of the realist synthesis clearly represents propositions to match against the data. However, Yin also asserts that the variables of the propositions need to be defined prior to data collection. As described in the previous chapter the realist synthesis was able to produce an initial programme theory from studies available on occupational therapy in reablement services. The case study data served as further data not just to confirm and refute the programme theory but to develop the theory further. In this case the propositions were not all defined prior to data collection.

The data analysis technique used in this study - explanation building - is asserted as a special type of pattern matching. Explanation building seeks, as the title suggests, to explain the how and why of the phenomenon under study (Yin, 2009). This clearly links with the realist methodology of searching for contexts and mechanisms supporting positive outcomes in practice. Explanations reflect the theoretical propositions and research questions of the study. Explanation building was an iterative approach that began with comparing the data of the first case study against the programme theory. The brief 'reading through' analysis of each case study led to the expansion and revision of questions for participants in the next case study to develop the programme theory.

4.10.2.1 Steps of data analysis

Yin (2009) does not suggest specific methods for undertaking the explanation building technique. Thematic analysis as described by Braun and Clarke (2006) was utilised as method to analyse the data. Thematic analysis seeks to identify, analyse and report themes in the data. In this study themes were identified at the latent level of elements of the programme theory, namely, contexts, mechanisms and outcomes. Within thematic analysis themes can be identified both inductively and deductively, also called ‘theoretical’ thematic analysis (Braun and Clarke, 2006). This aspect of thematic analysis supported Yin’s (2009) concept of comparing data with propositions in a deductive way, whilst also identifying new aspects of programme theory inductively.

Following the return of the transcripts from the participants all identifying information including names of workers, service users, organisation and places were changed to maintain anonymity of the participants. All data was read in full to gain familiarity with important aspects of each case study (excerpts from interview transcripts and observation notes are included in appendix L). Braun and Clarke (2006) assert that writing should be undertaken throughout the analysis process. I added comments to the transcripts as I read to record my initial analysis. This text was in an italic font in a different colour to the transcript for easy identification. An example of initial analysis written during an early read through of the transcript is included in Appendix M. Profiles were written of each case study to refer to outline structures and contexts, when analysing the data in full.

The interview and focus group transcripts and my observation notes were imported into NVivo software (QSR International, 2012) to support analysis of the data as recommended by other authors (Leech and Onwuegbuzie, 2011). Analysis involved both deductive and inductive coding. Analysis began with deductive coding. Using the theoretical thematic analysis technique different elements of the programme theory, developed from the realist synthesis, were entered as codes in the NVivo software to represent themes to compare with the case study data. Analysis was not restricted to use of these codes. Using an inductive method, analysis of the data revealed additional contexts, mechanisms and outcomes not identified in the realist synthesis and these aspects were coded. As each case study was undertaken

it was compared with codes from the previous case study data and new codes were added when new elements of occupational therapy practice were identified. These codes were collated into themes. I used the report feature of NVivo to produce a document of a particular theme or topic that included all references to a code and supported understanding of whether the original meaning of the code had changed over time. An example of a NVivo report on the code 'goal setting' is included in appendix M. Analysis included consideration of whether information from participants supported the theory, refuted the theory or added to the programme theory. At this stage an interview transcript was sent to my supervisor who provided comments on possible themes from the information given, that served as a marker on my initial thoughts.

Using the elements of the programme theory to code the data in NVivo resulted in separation of contexts, mechanisms and outcomes. Initially this enabled comparison of the different elements across the three case studies. Working on themes at the level of contexts, mechanisms and outcomes had an undesirable effect of splitting the contexts, mechanisms and outcomes so they were no longer configurations and it was difficult to see overall story of the configurations. Following a brief search for literature on this issue I opted to follow the practice of Punton, Vogel and Lloyd (2016) who utilised Microsoft Excel software to maintain configurations by recording contexts, mechanisms and outcomes in columns, with each row representing a configuration. All the contexts, mechanisms and outcomes identified during the deductive and inductive coding stages were entered on the relevant row into their respective columns on an Excel spreadsheet to represent the configurations. As suggested by Punton, Vogel and Lloyd (2016) a column for interventions was also added to distinguish between aspects of the reablement process. In addition, each aspect of the configuration was numbered sequentially to identify similarities and differences between the configurations (see appendix N for an excerpt from the spreadsheet).

The resulting CMO configurations (n=82) were then themed and compared with the four initial programme theories (presented in the previous chapter). Some CMO configurations were very similar to the CMO configurations, and subsequent programme theory identified in the realist synthesis such as in the provision of

equipment. Other CMO configurations did not relate to the initial programme theories and two new programme theories were developed in relation to occupational therapists working in a team and the impact of a shared purpose and 'buy in' to reablement. As suggested by Braun and Clarke (2006) in the final stage of thematic analysis 'Producing the report' numerous verbatim quotes from research participants are included in the findings chapter to demonstrate the source of the interpretation for the reader.

Whilst analysing text I recognised the link between observation notes and interview transcripts. For example my observation notes included visits to service users who were subsequently discussed during interviews. On some occasions I referred to service users that we had visited during interviews, to clarify or discuss the occupational therapist's actions. Occupational therapists also referred to the same service users during interviews. I sought to maintain a link between observation notes and interview transcripts in the form of vignettes. I was not using vignettes as they have been used in other settings as a data collection tool in the form of themed fictional short stories that participants comment on (Finch, 1987). The vignettes themselves were not coded they were developed from the analysis and are formed from both observation notes and interview transcripts. The style of my vignettes have been described as a snapshot vignette that focuses on a theme or concept (Ely, Vinz, Downing *et al.*, 1997). My vignettes were written to illustrate the role of the occupational therapist with specific service users, as described by the occupational therapists and have been used by others in this way (Spalding and Phillips, 2007). The vignettes enabled me to keep the analysis grounded in the data. A number of vignettes are included in the findings chapter to illustrate a certain concept for the reader.

Member checking, as previously described, can include sharing of the analysis of the data gathered. As the analysis is a result of reviewing all the data collected, an individual participant will only have contributed a proportion towards the final analysis. It is suggested that it is unlikely that participants will see themselves within the findings (Morse, 2015). Following the analysis of the data a conceptual framework of occupational therapists in reablement services was produced, presented in chapter six. This conceptual framework and a summary of other

findings from this research was presented at the Royal College of Occupational Therapists Annual Conference in 2017. Two participants, from two of the case studies, were present in the audience. This presented an opportunity for ‘member checking’ my analysis. Following the presentation I spoke to the participants to enquire whether could recognise their role in their setting from the findings of the result. In essence whether they could ‘see themselves’ in the findings. Both participants confirmed that they could see themselves in the findings presented.

The conceptual framework presented in chapter six was developed from the programme theory presented in the following chapter. The conceptual framework presents three time phases recognising that programme theories impact on the role of occupational therapists in reablement at different times. For example, having a remit for a reablement service is important before the reablement service begins in order for occupational therapists to understand the scope of their role. The four contextual layers in the framework demonstrate structures and agency; how different parties influence each other. The conceptual framework focusses on the contexts and mechanisms that lead to positive outcomes in reablement. Contexts, mechanisms and outcomes are separated from their configurations to illustrate how these concepts impact in different time phases and contextual layers. The conceptual framework links the findings of this study to practice. It provides concepts for practitioners and managers to consider when designing and implementing a reablement service, providing evidence of the role of occupational therapists in reablement.

4.11 Profiles of the case studies

The final section in this chapter provides a profile of each of the case studies. These are presented to support contiguity for the reader as suggested by Maxwell (2012). It presents the reader with a description of the contexts of each case study.

4.12 Tollbury profile

4.12.1 Demographics of the area

Tollbury was located in a large rural county in the south of England. Occupational therapists described the county as ethnically diverse. Census results record that

88.9% of citizens were white British, higher than the average in England and Wales of 80.5%. 2011 census data showed variation across the county with one area recording just over 70% White British with just under half of the remaining percentage being Asian. Census data from 2011 also recorded that 82.5% of the population described themselves as in good or very good health, slightly above the national average.

4.12.2 Structure of the service

The reablement service consisted of occupational therapists, occupational therapy assistants and a manager, who was also an occupational therapist, employed by the Local Authority. The Local Authority arm of the reablement service consisted of three teams covering different geographical areas of the county, based on density of the population. Whilst the occupational therapists were assigned to a team they worked between teams if necessary to cover annual leave or sickness. Occupational therapists were employed to work Monday to Friday.

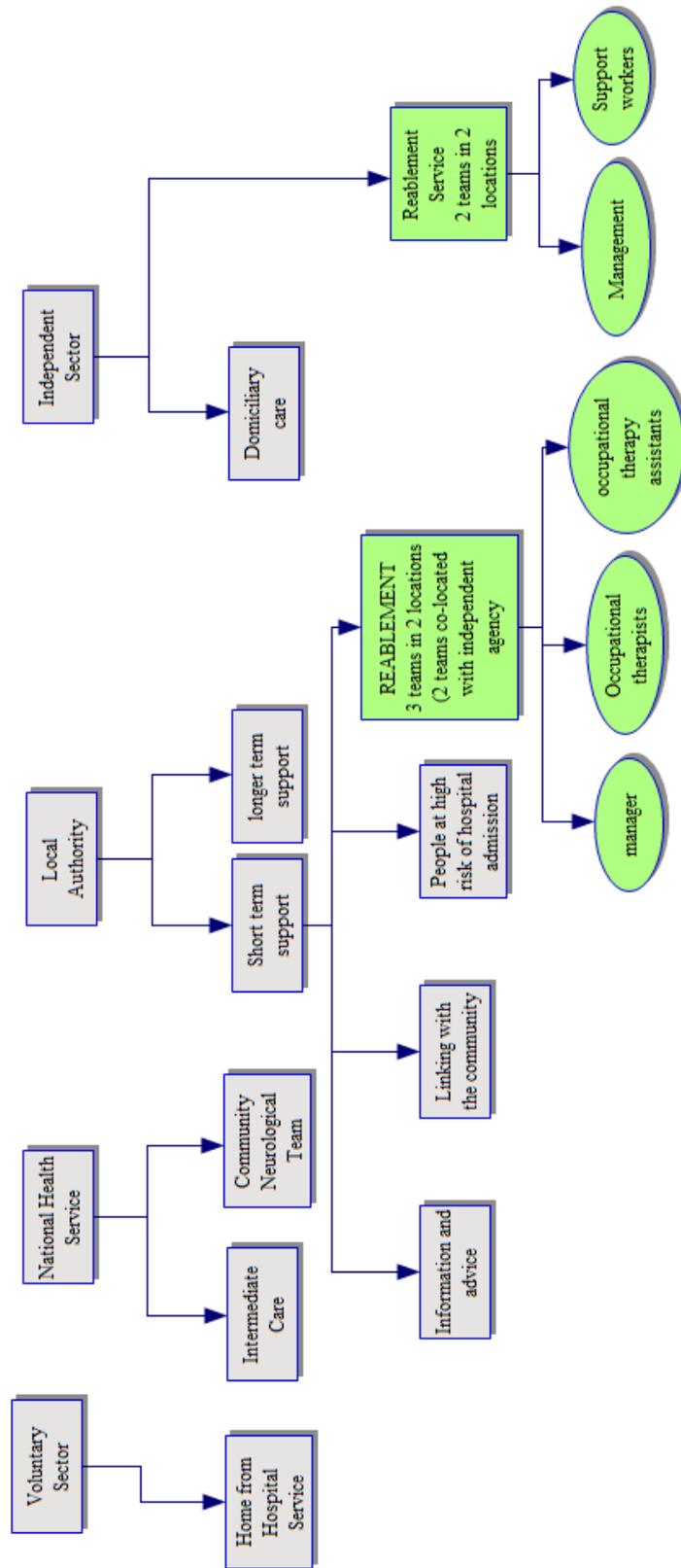
Support workers for the reablement service were commissioned from one domiciliary care agency, thereafter called the independent organisation. The support workers, their management and administrative staff were divided geographically into two teams. Support workers visited service users in their own homes based on a rota. They started work from home and were not required to visit the offices each day. In one area of the county the Local Authority arm of the service was co-located with the independent organisation staff.

The reablement team within the Local Authority was one of a number of short term and long term teams as shown in figure 5. One team worked with people at high risk of admission to hospital. Another team were commissioned to support people on a time limited basis to link with social facilities in their community. A further team provided advice, advocacy and information on services for service users not eligible for funded support from the Local Authority. The voluntary sector provided a 'home from hospital' scheme to support people with domestic tasks.

The NHS also employed teams working in the community. A community neurological rehabilitation team were described as a specialist team working with people with neurological conditions. The intermediate care team worked with

service users with multi-disciplinary needs, for example they had needs that required support from at least two of the disciplines of occupational therapists, physiotherapists or nurses. The reablement team advised that they referred to the intermediate care team if the service user's needs were primarily caused by a health issue such as the service user having a urinary tract infection affecting their mobility.

Figure 5 Services in the Tollbury community



4.12.3 Remit of the service

An information leaflet for service users on the reablement service described reablement as a short term service for up to six weeks with the aim 'to support you to do as much for yourself as you are able to'.

The service was free for the service user. The reablement team accepted service users to the service both from the community (own homes) and from hospital. Service users themselves or family and friends - with the service user's consent - could refer to the service via a specialist team of advisors within the Local Authority. All referrals with an apparent need for support from carers were referred to the reablement service to be screened by an occupational therapist. Service users referred from the community were assessed within 48 hours.

The reablement service received referrals directly from occupational therapists in hospital settings. Some service users in hospital were assessed by social workers in the hospital who agreed goals and initial reablement support. These service users were then assessed by occupational therapists from the reablement service within 5-7 days of being at home.

4.12.4 Eligibility for reablement

Data collection in Tollbury was undertaken before the implementation of the Care Act, 2014, as the main legislation currently underlying social care provision in England. Prior to the implementation of the Care Act the Fair Access to Care Framework provided a framework that guided the eligibility for social care service (Department of Health, 2010a). The framework consisted of four bands: critical – where life may be threatened, and a person may be unable to carry out everyday activities; substantial – where a person may only have partial choice and control and be unable to carry out the majority of their daily activities and social roles, moderate – where people are unable to carry out several activities or family and social roles; and low, described as being unable to carry out one or two daily activities, role or relationships.

The Local Authority in Tollbury only provided services for those that met critical and substantial criteria. Service users with moderate or low needs were provided with information about funding services themselves. However, if service users had

moderate needs that had the potential to become substantial needs within a short time scale then they could be assessed by the reablement team to discuss needs and potential support from the reablement service.

4.12.5 Records

Occupational therapy staff used computer software to allocate service users to staff and to record assessments, reablement plans and review documentation. The independent organisation used a separate computer system. Paper records were held in service users' homes, in the form of a file containing information about the reablement service and their reablement plan. Staff who visited the service user at home recorded information in the file.

4.12.6 The pathway following reablement

Following a period of reablement service users requiring further support were passed to the main social care team to review the service user and complete an assessment for longer term care support. Social care workers used the occupational therapist's assessment and notes to inform their review. Occupational therapists in the reablement team did not undertake the reviews with social care workers. During the time of data collection social care workers were not up to date with reviews for service users. As a result service users were delayed in being referred for longer term support and continued to be supported by the reablement team.

4.13 Foybrook profile

4.13.1 Demographics of the area

Foybrook was based in an average size suburban county in the south west of England. The population was 91.9% white British, and 84% described themselves as being in good or very good health (Census data from 2011). Both figures are higher than the national averages of 80.5% and 81% respectively.

4.13.2 Structure of the service

Reablement was described as the central ethos of social care in Foybrook, meaning that all teams in social care focussed on supporting people to do more for themselves. The access team were the first point of contact to adult social care

dealing with needs requiring a quick response. The Local Authority element of the reablement service consisted of separate arms including reablement from the community, reablement at discharge from hospital, inpatient beds in community hospitals with a reablement focus and reablement in prisons.³

One domiciliary care agency (independent organisation) was commissioned to provide a set numbers of hours of support workers for the reablement service. The support workers worked on a shift system covering 7am to 10pm. They were organised into three teams to cover the geographic area most efficiently. Support workers were employed as senior carers recognising their additional responsibilities in reablement to complete risk assessments and discuss and agree weekly goals with service users. The independent organisation employed team leaders who received referrals from the Local Authority and organised the rota of visits for the support workers.

Other services available in the community were a home from hospital scheme provided by the voluntary sector and rehabilitation teams led by the NHS (see figure 6).

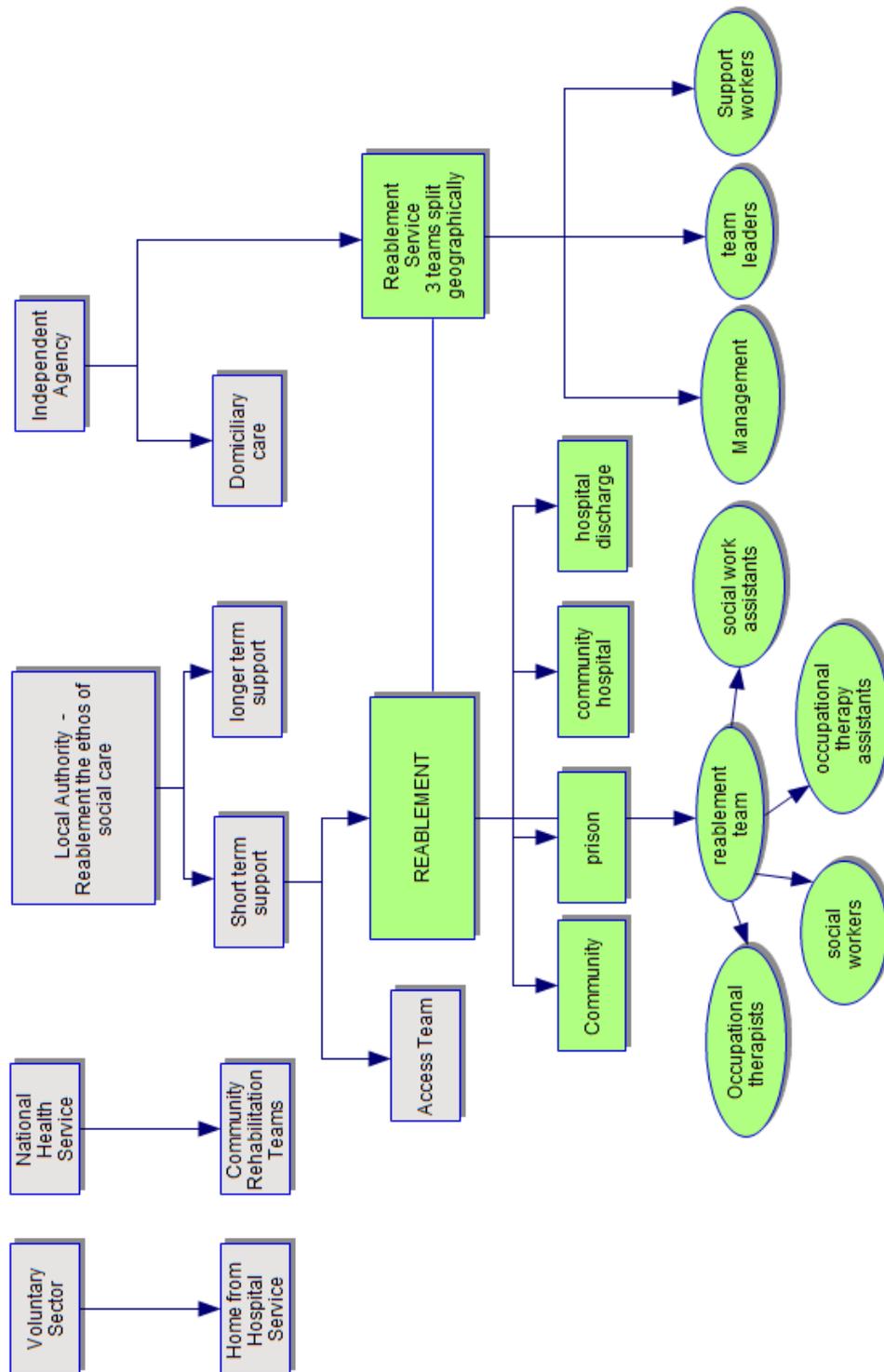
4.13.3 Remit of the service

Information leaflets described reablement as ‘a stepping stone to independence by supporting you to regain life skills and control, enabling you or your carers to be experts in your own care and avoid care solutions which foster dependence’.

Reablement was a short term service for up to six weeks. There was flexibility in the timescale as reablement could be extended if, for example, if there was a delay in the provision of equipment. It was expected that all service users identified as

³ Data collection was undertaken following the implementation of the Care Act, 2014 that places a responsibility on Local Authorities to assess the social care needs of prisoners and provide support in line with what service users in the community may receive (with some exceptions concerning choice of provision and that prisoners cannot have a direct payment to pay for care and support).

Figure 6 Services in the Foybrook community



needing care at home would be seen by the reablement service. Anecdotally, occupational therapists and support workers reported that most people (80% was given as a figure) being supported by the reablement service were service users discharged from hospital.

Assessments for reablement from the community, in prison and the community hospital setting were undertaken by occupational therapists. Assessments for service users being discharged from hospital were undertaken by either occupational therapists, social workers, occupational therapy assistants or social work assistants. Senior practitioners (occupational therapists and social workers) screened referrals and allocated cases to different members of the team. Occupational therapy assistants were allocated service users who were considered to have less complex needs.

Goals for reablement were reviewed weekly by the support workers with the service users, with feedback to occupational therapists if required. Occupational therapists (and other staff who completed assessments and goal planning for reablement) reviewed the progress of reablement part way through the support, usually after three weeks, to determine whether ongoing support may be required.

Reablement in Foybrook also had a specific remit named the 'double handling initiative project'. This project included occupational therapists working with service users, their carers and support workers on moving and handling techniques to reduce visits undertaken by two support workers to a single carer. The project involved providing different types of equipment and adaptations and advising of alternative techniques to enable one person to support the service user safely with moving and handling tasks such as getting out of bed.

4.13.4 Eligibility for reablement

The reablement service was provided as a preventative service. As such it was a short term service undertaken to increase the independence of service users prior to a determination of eligibility for funded care and support, under the Care Act 2014.

4.13.5 Records

Assessments, goals, reablement plans and records of visits were held on a purposely designed computer software system. Some staff had computer tablets that enabled them to upload a template assessment to the tablet prior to an assessment visit. The information could then be uploaded to the computer when back in the office. No information was captured on tablets by occupational therapists during observations. All reablement plans were read and authorised by a senior occupational therapist or social worker before being sent to the independent organisation.

Reablement records are not able to be seen by the community health teams and the reablement teams were also unable to see community health team records.

4.13.6 The pathway following reablement

Following reablement if further support was required this was commissioned from a range of independent domiciliary care providers. During the time of data collection support workers in particular highlighted the reduction of the number of domiciliary care agencies working within their area and the reduced capacity of the remaining providers. This resulted in the reablement service supporting people for longer than expected whilst the service user was waiting for another care agency to be able to commence care visits with them.

4.14 Averdale profile

4.14.1 Demographics of the area

Averdale is a small mixed urban and rural county in the South West of England with 90% of the population identifying themselves as white British in the 2011 census (national average 80.5%). Census data from 2011 also recorded that 84% of the population described themselves as in good or very good health, 3% above the national average.

4.14.2 Structure of the service

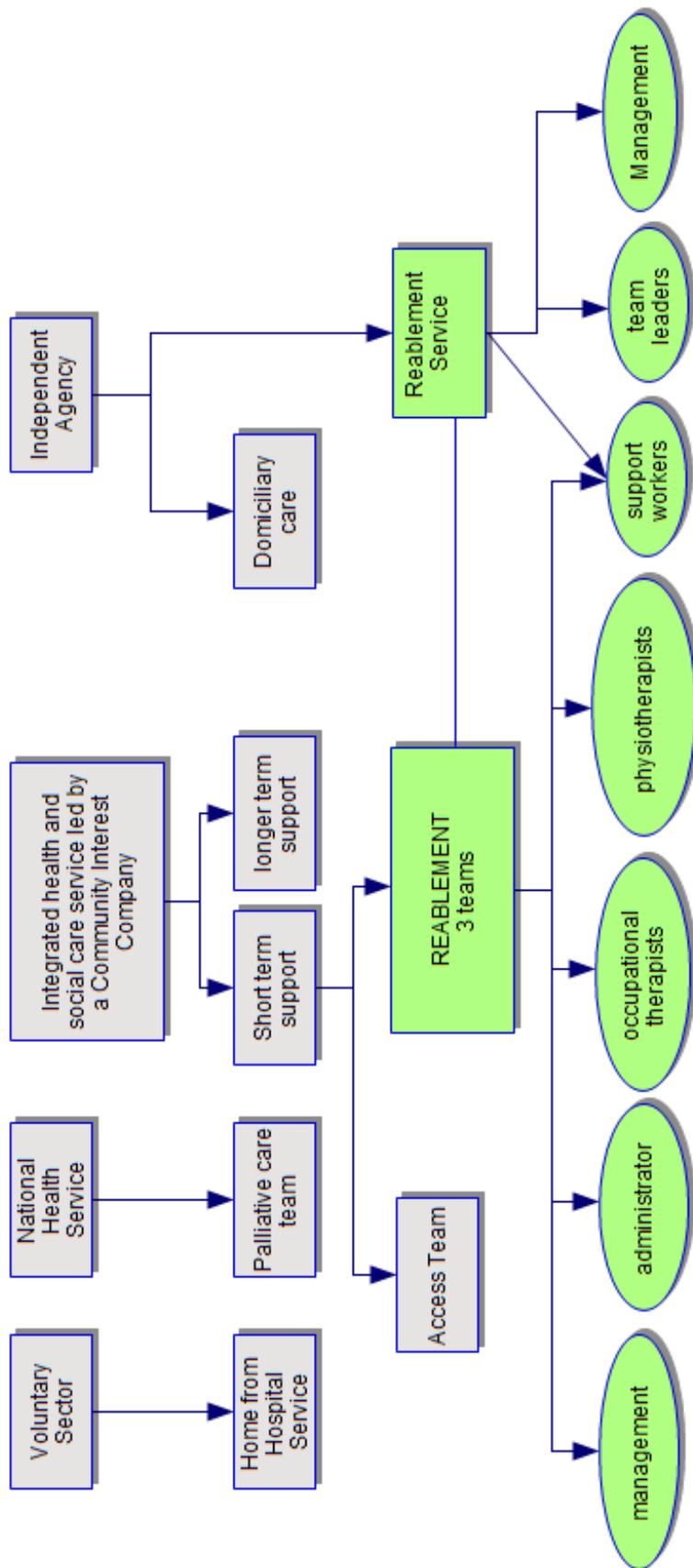
Averdale was an integrated health and social care service run by a Community Interest Company. The reablement service consisted of three teams covering the Local Authority in geographical areas (see figure 7). All participants in the research

were based in the same team. The service was managed by an occupational therapist. The teams consisted of occupational therapists, physiotherapists and an administrator. The team also employed their own support workers. These support workers worked a shift system supporting service users assessed initially by either an occupational therapist or a physiotherapist. These support workers were regularly present in the office during the day to ask questions, attend meetings and complete their documentation.

A domiciliary care agency (independent organisation), was commissioned to provide additional support workers to undertake reablement. These support workers started work from home and visited the organisation's offices for meetings and discussions with their supervisors. The independent organisation employed reablement team leaders who were responsible for completing initial assessments and setting goals for reablement for some service users. Support workers fed back to the team leaders after each visit to enable them to track the progress of the service user in weekly review meetings. At these meetings a need for an assessment by an occupational therapist may be identified.

There was no separate health commissioned intermediate care or community rehabilitation team in the area. The occupational therapists in the reablement team advised that their role included seeing all service users who required rehabilitation and reablement in the community. There was a specialist palliative care team. Some service users were referred to the reablement service from the palliative care team.

Figure 7 Services in the Averdale community



4.14.3 Remit of the service

The reablement service was designed to be a short term service, up to six weeks. The information leaflet on the reablement service for service user describes reablement as 'short term therapy and support to prevent hospital admission, to facilitate early hospital discharge and to provide rehabilitation and support in order to help people maintain/regain their independence'.

The reablement service had written key service objectives:

- Preventing admission to hospital
- Facilitation of planned discharge from hospital
- Planned rehab based on assessment of need by a therapist
- Stabilising care plans
- Supporting individuals in regaining as much independence as possible
- Determining the appropriate level and type of service for ongoing needs.

In line with the key service objectives there were many strands to the service in Averdale. Service users were referred to reablement following an admission to hospital if they were mobile and were considered to be safe between visits. Occupational therapists assessed service users on the day they were discharged from hospital.

To avoid hospital admissions the reablement service worked with the ambulance service for service users who had had a fall that did not require medical attention. The reablement service had equipment to support people to get up from the floor and could provide short term support from their support workers.

Service users could be referred to reablement from their own homes if a need for support was identified. If the service user experienced a change in their health, such as having an infection, they were assessed by an occupational therapist or physiotherapist in the reablement team and a reablement package was set up. Service users who appeared to be experiencing a change in their social care needs such as carers not being able to support or a general deterioration of a health condition were referred directly to the domiciliary care agency who assessed the

service user and set goals. This arm of the service had a remit of determining how much support was needed in the longer term.

Occupational therapists worked on a rota system covering seven days a week. One occupational therapist was allocated to 'urgent' work each day. Examples of urgent work were service users discharged from hospital on short notice. The occupational therapist would complete the assessment and continue to work with the service user.

4.14.4 Eligibility for reablement

Occupational therapists described the service as working with NHS guidance and legislation and social care legislation of the Care Act, 2014.

4.14.5 Records

Occupational therapists held records for referrals, assessments and visits on a computer database. These electronic records were available for district nurses and some GP surgeries to view and add records to. The records did not link to the social care electronic records. Staff had computer tablets to record visits; although some occupational therapists reported that information did not always synchronise with the computer system and this reduced confidence in using the tablets to record their work.

Paper records were held in the form of a file kept in the service user's home. The file contained information about the reablement service and workers who visited the home wrote in the file.

4.14.6 The pathway following reablement

Following reablement service users requiring ongoing support were referred to social workers in the adult social care department. Care was provided via a number of independent domiciliary care providers. During the time of data collection there was limited availability of support from domiciliary care providers and the reablement team continued to support people whilst waiting for another agency to support the person on a longer term basis.

4.15 Summary

This chapter has presented a dense description of the methodology and methods of phase two of this research. It has presented the qualitative approach of this research, considering the use of this methodology in occupational therapy and issues of quality in qualitative research. This chapter has provided detail on the recruitment of participants, methods of data collection and data analysis.

Thirty one participants were recruited to this study, twelve days of observation were undertaken visiting 20 service users at home and one in a hospital setting. This chapter concluded with a dense description of the case study sites to provide context for the following chapter, the findings of this study.

5 Findings

5.1 Presentation of findings

The research questions for this study are focussed on understanding the role and impact of occupational therapists in reablement services; and the contexts and mechanisms that affect outcomes for service users, carers and other team members.

The realist synthesis review of the literature identified five context mechanism outcome (CMO) configurations, presented as 'if...then' propositions, that were developed into four programme theories (presented as a reminder for the reader in box 5). Identification of programme theories concerning the role of occupational therapists in reablement services was limited by the number of sources available in the literature. This chapter seeks to confirm or refute the programme theories identified from the literature, in addition to presenting new configurations and theories identified from the research data. CMO configurations are presented with the findings of each programme theory. Two new programme theories were identified from this study, presented in box 6, below. This chapter includes some discussion of findings. This discussion and critical analysis will be considered in more depth in the following chapter.

Box 5 CMO configurations and programme theories

CMO Configurations

Outcomes for Service users and carers

1 If occupational therapists are involved in goal setting and designing reablement plans with service users (C) as other members of the reablement team have recognised the need for the occupational therapist's skills and knowledge (M) then realistic, structured reablement plans enable support workers to work with service users to increase their independence in daily occupations (O)

2 If occupational therapists have knowledge of the impact of disability on a service users ability to carry out daily occupations they need and want to do (C) and complete assessments and goal setting with service users (C) using a holistic approach (M) then the occupational engagement of service users in all areas of their life increases (O)

3 If occupational therapists provide timely access to equipment (C) and service users and carers accept that equipment (M) then service users can do more for themselves (O)

Outcomes for reablement team members

4 If occupational therapists are involved in regular contact with reablement support workers including training sessions (C), support workers increase their skills and confidence (M), feel valued (M), practice in a reabling way with service users (O) and report increased job satisfaction (O)

5 If occupational therapists are involved in training reablement support workers (C), role blurring can occur (M) and support workers can assess for and provide equipment for service users (O)

Programme theories

1 Recognition of the skills and knowledge of occupational therapists by staff in reablement teams determines the degree of which occupational therapists support service users and carers.

2 The skills and knowledge of occupational therapists can be utilised in assessment, goal setting and the development of plans in a holistic way for reablement to support the occupational engagement of service users in areas of daily life.

3 The timely provision of equipment increases the independence of service users and supports carers in their caring role.

4 Occupational therapists contact with support workers, including involvement in training, increases the skills and confidence of support workers and assists support workers to work in a reabling way.

Box 6 New programme theories

5 Regular face to face contact including co-location and regular meetings supports communication, encourages trust, a team approach and an understanding of one another's roles; and enables a joint approach to decision making.

6 A shared purpose of reablement by service users, occupational therapists, support workers and legislation supports engagement and collaborative working with service users, increased satisfaction by support workers and occupational therapists confident in assessment and the reablement approach.

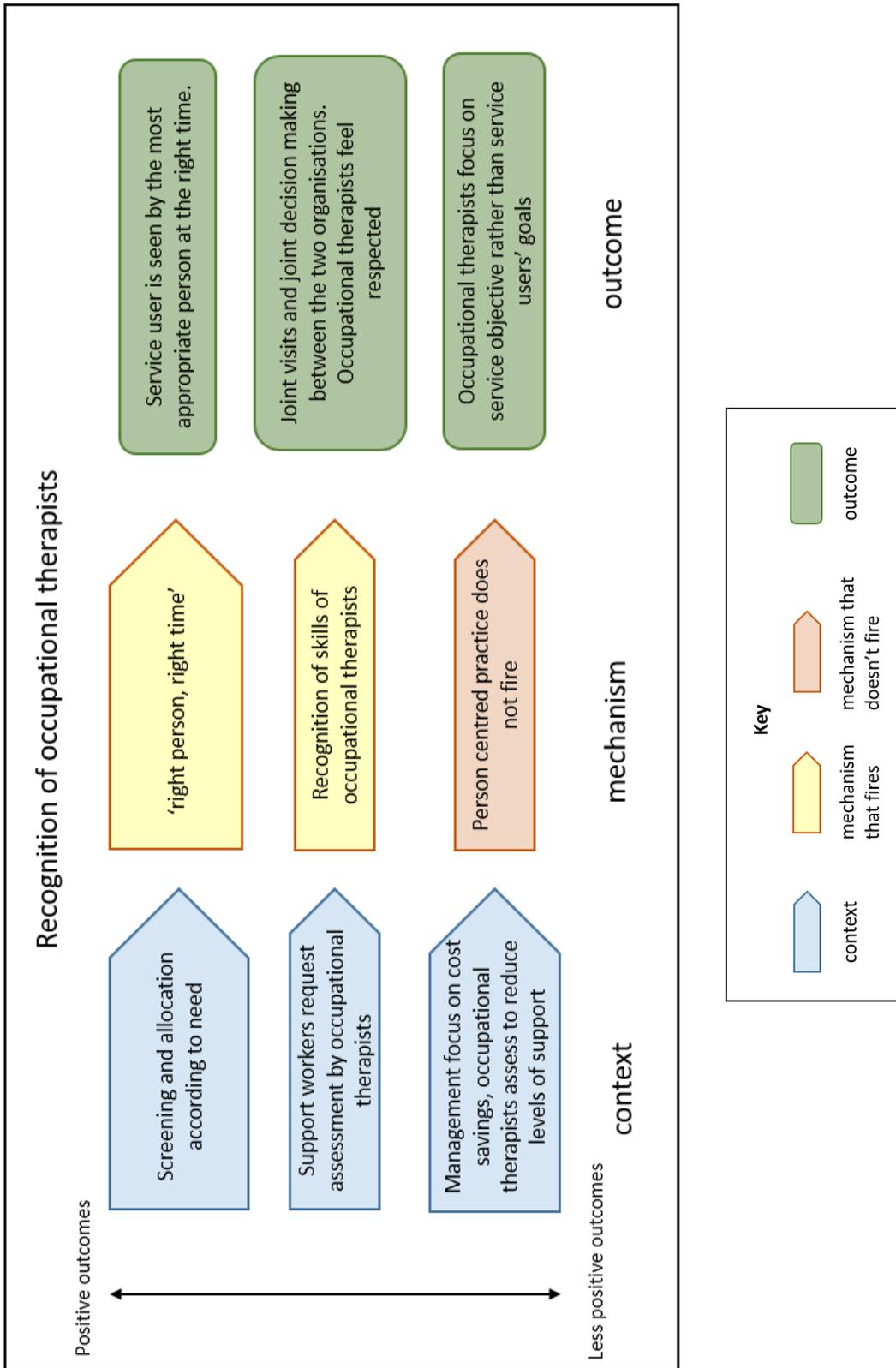
5.2 Programme theory 1 – recognition of the role of occupational therapists

The first programme theory (box 7) hypothesised that the contribution of occupational therapists in reablement was linked to the recognition of their skills and knowledge by staff in the reablement team. The literature supporting this programme theory was either the professional opinion of occupational therapists or findings from reablement studies that requested occupational therapists to undertake a specific role, for example an assessment for equipment.

Recognition of the skills and knowledge of occupational therapists by staff in reablement teams determines the degree to which occupational therapists support service users and carers.

Box 7 Programme theory one - recognition of occupational therapists

Figure 8 CMO configurations - recognition of occupational therapists



This programme theory was tested during data collection and figure 8 illustrates the three context, mechanism, outcome (CMO) configurations that emerged from the case study data. In contrast to findings from literature, occupational therapists in each of the case studies in this study were core members of the team involved in assessments, writing reablement plans and reviewing service users. The degree to which occupational therapists supported service users was defined by two factors: the screening and allocation of work and requests for support from others.

5.2.1 Right person, right time'

Reablement services in each of the three case studies consisted of different staff members with different skills and different professional roles (see organisation charts in previous chapter). The mechanism of 'right person, right time' is the concept of selecting the most appropriate member of the team to work with a service user at all stages of reablement. In Tollbury assessments for reablement were undertaken by occupational therapists and occupational therapy assistants. In Foybrook assessments were undertaken by occupational therapists, social workers, occupational therapy assistants and social work assistants. In Averdale assessments were undertaken by occupational therapists or physiotherapists.

Screening was a context that supported the mechanism of 'right person, right time'. Screening was completed by senior members of the team who made an initial judgement on who would be the most appropriate person to assess a service user based both on presenting need and the skills and experience of different members of staff. In Foybrook, for example, a senior practitioner advised that a service user with moving and handling needs would trigger an allocation to an occupational therapist, whilst a service user with mental capacity needs would be allocated to a social worker. Similarly in Tollbury occupational therapy assistants were allocated service users who were considered straightforward. Occupational therapy assistants were not allocated service users who, for example, had moving and handling needs, which was considered as a more complex piece of work.

5.2.2 Seeking recommendations to support practice

There was evidence of a recognition of the skills and knowledge of occupational therapists. Support workers sought advice and assessment from occupational therapists to support them in their work. This included requesting an assessment of skills of the service user, support with moving and handling needs and provision of equipment.

In Averdale support workers recalled working with a service user who needed help with preparing food. The support workers asked for an occupational therapist to assess the service user's kitchen skills. The support workers then worked with the service user based on the recommendations of the occupational therapist.

Seeking support was part of a joint approach to working with the service user based on the assessment of occupational therapists and the experience of the support workers. Managers said:

'obviously the staff are very experienced but they're not occupational therapists. So if they're coming up against something that they're not really sure how to go about it then they would discuss it with an OT' (Maisie, Foybrook).

'it's dependent on the individual's needs. Generally we will do joint visits with them [occupational therapists]. We will liaise with them throughout, seek advice.... It's just really working together as a team to try and achieve the best possible outcome for the service user. So it might be that that person needs a piece of equipment, that the OT might need to go out and have a look and establish whether that would be suitable. So we might suggest and they might think 'yes that's a good idea' or 'actually no'. They might suggest something else. So it is really about the interaction' (Carolyn, Averdale)

Support workers advised that they would suggest potential equipment options for service users they were working with. They recognised that the final decision was the responsibility of the occupational therapist:

'we go with their judgements because they are trained occupational therapists' (Joy, Support Worker, Foybrook)⁴

The assessment of moving and handling needs was seen as a particular domain for occupational therapists. Managers sought advice to support best practice both for their support workers and service users:

'things like how someone should be supported if they're in the bed with different slide sheets, equipment, things like that. Making sure that we're doing it in the best possible way, so that it's the least intrusive for our service users. So that works really well'.

(Carolyn, manager, Averdale)

Occupational therapists used non-standardised moving and handling risk assessments approved by their organisations. If a moving and handling difficulty was identified a moving and handling risk assessment was completed in line with the Moving and Handling Operations Regulations (1992) (Health and Safety Executive, 2004). Team leaders in Foybrook confirmed that for each service user they supported with moving and handling needs, the occupational therapist would send a moving and handling plan that the team leaders encouraged the support workers to read at every visit. The importance of occupational therapists in assessing moving and handling needs was highlighted in Tollbury and Averdale that included a specific moving and handling project as part of the reablement service. These projects were concerned with reducing the number of support workers required to support a person where possible, and were often called 'double handed care' projects.

5.2.3 Doubled handed care

A typical scenario for assessment under a double handed care project involved a person who had lost their ability to mobilise and two support workers were needed to support the service user, often at numerous times throughout the day. The service users were no longer able to walk or bear weight and support workers used hoists or other equipment to, for example, move the person from their bed to

⁴ Quotes are sourced in the format (participant, job role, case study) all pseudonyms from table 6 in chapter four

a wheelchair. The remit for the occupational therapists was to recommend techniques or provide equipment to enable care to be delivered by one support worker if possible.

Finance was a clear context that underpinned the drive to work with people who were supported by two carers. Occupational therapists were clear that their remit was to reduce ongoing costs for the Local Authority and they did not hide this fact from service users. During one home visit the occupational therapist discussed providing a ceiling track hoist for the service user that could be used by one support worker. She explained that this would be more financially effective than continuing to fund two support workers to assist at each visit. Following the home visit the occupational therapist reflected that she had visited the service user with a plan to provide a ceiling track hoist to reduce the number of support workers required, based on feedback from another occupational therapist who had recently worked with the service user in a community hospital. This reflection demonstrates the impact of the reablement service remit to reduce care provided from two carers to one carer. In the above example the mechanism of being person centred focusing on the goals of the service user did not fire.

Occupational therapists had mixed opinions of whether involvement in a double handed project should be an element of a reablement service:

'Well I don't see that as reablement because for that service user I'm not changing anything physically for them. I didn't enable her to do any more than she was when she was having double handed calls. All I've done is, I've gone in and put in a ceiling track hoist and her budget now fits under social services so she can stay at home. I mean the fact that I've enabled her to stay at home is fantastic and that was the goal originally for her to stay at home but is that reablement?' (Gill, Tollbury)

Double handed projects were recognised as working alongside rather than an integral role of the reablement service. One senior occupational therapist asserted that different skills were needed for support workers to be confident in assisting a service user with moving and handling on their own, compared to working with a service user on relearning how to make a cup of tea (Chloe, Foybrook). In other

teams the reduction of care, from two support workers to one, was a goal of a service user and reablement was key to achieving that goal. In her interview, Angela, occupational therapist in Foybrook, provided an example of a service user she had worked with that went well that is condensed into the following vignette.

Connie⁵ was discharged home following a hospital admission as a result of a stroke. Connie was not able to move on her own and was assessed in hospital to need visits four times a day by two carers, to move in bed. Connie was motivated to return home. She shared with Angela that she struggled with having two carers supporting her as she was a very private lady.

Initially the independent organisation employing the support workers were reluctant to provide reablement support as Connie had been receiving a substantial amount of support before going into hospital (three visits per day). Following initial reluctance Connie received support from reablement. Angela established that Connie wanted to do as much for herself as she could and they set goals with regard to Connie washing her face, brushing her hair and choosing her clothes. The period of reablement provided an opportunity to assess for, and try moving and handling equipment; and alternative seating was also provided. The reablement team worked with Connie to establish a routine with equipment to support her to take her medication. The second support worker allocated to visit Connie was asked to stand back to establish what level of support was required. Angela ascertained that the support could be provided by one support worker and visits were reduced from four visits with two support workers to three visits per day with one support worker over a series of days. Angela advised that encouraging support workers to 'stand back' had achieved the added benefit of the support workers understanding the value of enabling the person to do more for themselves.

Vignette 1 A reduction in support required for Connie

⁵ All names of service users are pseudonyms

5.2.4 Occupational therapy involvement in the development of reablement services

One reason for the inclusion of double handed care moving and handling projects, as an element of the reablement service may be attributed to the development of the reablement service. In all case studies occupational therapy managers had been involved in the development of the service and managers interviewed highlighted a link between occupational therapists and reablement:

'reablement is all about empowering people and that is what occupational therapists do. It's the core of who they are, what they should be' (Emily, manager, Averdale).

The link between occupational therapy and reablement is presented further in the shared purpose theory, section 5.8.1. One occupational therapist felt strongly that being involved in the design and delivery of reablement had 'transformed' the view of occupational therapists providing a clear role definition ensuring occupational therapists were *'at the forefront of social care'* (Angela, Foybrook).

5.3 Programme theory 2 – holistic and person centred practice

The second programme theory (box 8) hypothesised that occupational therapists use a holistic approach in different aspects of their practice supporting improvement for service users. Analysis of data from case studies identified wider mechanisms that led to positive outcomes including rapport and trust, a collaborative approach, person centred practice and clinical reasoning. The mechanism named 'safety override' fired when the occupational therapists identified risk.

The context of policy and procedures of the reablement organisations negatively affected the ability of the person centred mechanism to fire (represented with an orange arrow), leading to poorer outcomes for reablement. Reablement was asserted as limited when financial limitations restricted the remit of the reablement service to focusing on occupations within the home.

The skills and knowledge of occupational therapists can be utilised in assessment, goal setting and the development of plans in a holistic way for reablement to support the occupational engagement of service users in areas of daily life.

Box 8 Programme theory two - holistic and person centred practice

The context mechanism outcome configurations that were developed from the data are presented in figure 9. These configurations will be presented following the stages of occupational therapy intervention: assessment, goal setting and deciding on reablement support; in line with the programme theory.

5.3.1 Working with the ‘whole person’ – being person centred

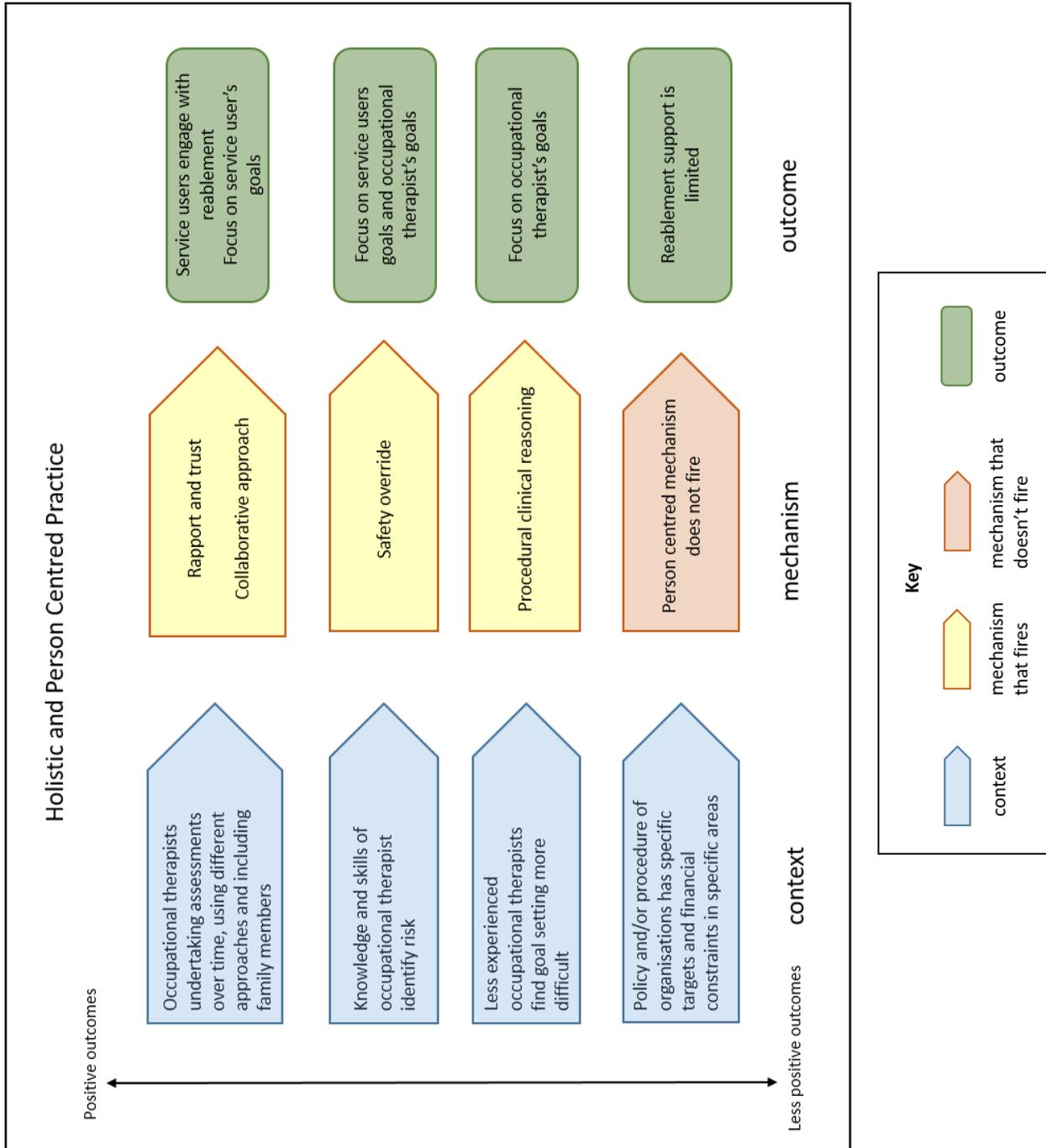
Occupational therapists presented their role as person centred; working with, what they described as, the ‘whole person’. This could also be described as being holistic in their practice. Occupational therapists asserted that their assessments and goal setting were centred on the service user:

‘the way OTs⁶ see things is very different. We are very person centred....we are looking at the individual’ (Clare, Tollbury)

‘[Occupational therapists] are in a good position to assess... the whole. Perhaps not just looking at one particular task or one particular aspect of function but being able to look at it as a whole and are perhaps quite well placed to try and reintegrate someone into the community as opposed to just doing an assessment of function. Trying to enable them to access...their lunch club or walking down to their garden or their bus stop or whatever. I think OTs are quite well placed to do that perhaps more than any other discipline’ (Zoe, Averdale).

⁶ OT is a shortened form of occupational therapy or occupational therapists used in this thesis only when directly quoted by participants.

Figure 9 CMO configurations - holistic and person centred practice



5.3.2 Assessment

Occupational therapists demonstrated a person centred approach during observed visits to service users. This included occupational therapists inviting narrative from service users on their story and of what had changed for them to lead them to a referral to the reablement service. Open questions were asked about daily occupations such as *'what do you usually have for breakfast?'* and to ascertain service users' perspectives:

'what do you feel at the moment that you are having difficulties with?'

(Gill, occupational therapist, Tollbury).

During observations occupational therapists used everyday language when assessing the abilities of service users such as:

'Can I see how you get on and off the toilet, and in and out of bed?'

(Pete, occupational therapist, Tollbury).

Occupational therapists also asked specific questions about health conditions, pain and shortness of breath. They listened to service users and reflected back the words of service users to demonstrate understanding. Occupational therapists described assessment as a continual approach rather than a one-off activity guided by the service user.

'...you go back out and just with talking they might mention that they're having difficulty with getting out of the house which is something which previously they said "oh no there's no problems" and then just in chatting they say "well I wasn't able to do this yesterday actually'

(Barb, occupational therapist, Tollbury)

Visiting service users on a number of occasions enabled the development of rapport with service users to support assessment of needs, based on conversation and observation.

Using a person centred approach was evidenced in written assessments. In Foybrook reablement coordinators in the independent organisation described reablement plans written by occupational therapists as including information

about the likes and dislikes of the service user and their goals alongside details of medical history and previous support.

5.3.2.1 Approaches to assessment

The approach taken by the occupational therapists was observed to be dictated by the situation rather than the style and personality of individual occupational therapists. For example during the course of a day observing one occupational therapist she asked direct questions during an assessment of one service user, using the assessment form as a prompt. At the next visit the occupational therapist asked questions as topics arose in the service user and his wife's conversation. For example asking about shortness of breath when the service user advised that he had a pacemaker fitted. The occupational therapist discussed after the visit that she had recognised that the service user had cognitive difficulties when he appeared not to understand some of the occupational therapist's questions. She made use of observation by asking the service user to demonstrate activities that others reported he had difficulty with.

5.3.2.2 Occupational Performance assessment

Assessment was viewed as 'key' to problem solving involving the consideration of occupations a service user needs or wants to do, establishing needs, analysing the causes of needs and debating intervention to meet those needs. Occupational therapists discussed the importance of assessing current needs, changes in function (occupational performance) and the potential to change within the short timescale of reablement services. For one occupational therapist assessing a service user's potential was the '*whole ethos*' of occupational therapy and reablement (Clare, Tollbury).

Occupational performance assessments were described as a means of understanding the difficulties for the service user focusing on occupations such as the ability of a service user to wash and dress, or complete kitchen activities. These assessments involved listening to service users concerns and observing service users undertaking daily occupations in their own environment. For example, Barb (occupational therapist, Averdale) in her narrative of working with a service user that went well, described completing a kitchen assessment in which she assessed

that there was only a small amount of space. She worked with the service user to move items around in the kitchen environment to support the service user to do all she could. This demonstrated a collaborative approach.

Assessment also included a physical assessment of service users in some cases, for example during a visit to a service user, Hannah (Averdale) noticed that the service user had a tremor in her feet and asked the service how long she had had the tremor. Hannah asked the service user to put her hand in her lap to assess whether she experienced hand tremor. Hannah utilised her experience and knowledge in making the decision to include a physical assessment during her visit. In discussion later, Hannah explained that she suspected that the service user may be developing Parkinson's disease and would pass on her concerns to the service user's doctor.

The documentation that occupational therapists completed in each of the case studies was a context that supported a functional, occupational performance based approach. In Tollbury for example the assessment documentation had headings of different occupations such as personal care, and mobility around the home. Occupational therapists were prompted to record capabilities, constraints and details of the environment.

5.3.2.3 Standardised assessments

Standardised assessments are assessments that have been tested to demonstrate credibility and validity for different topics and settings. Standardised assessments typically produce scores and the assessment can be repeated following intervention to enable scores to be compared and progress determined. Occupational therapists in all case studies had either trialled, or were currently using standardised assessments. These included assessments of falls with the Tinetti Balance Assessment Tool (Tinetti, Williams and Mayewski, 1986), skin condition using the Waterlow score (Waterlow, 1985) and general assessments of ability in daily living occupations including the Barthel Index (Colin, Wade, Davies *et al.*, 2008 2008) and the Morrision Occupational Therapy Outcome Measure (MOTOM) (James and Corr, 2004). There was no one standardised assessment identified that served as an assessment for reablement support as a whole.

Occupational therapists in Averdale were using the Barthel Index although considered it not sensitive enough for the reablement setting. The Canadian Occupational Performance Measure, an assessment from the Canadian Model of Occupational Performance and Engagement (Sumsion, 1999), was also trialled in Averdale. Two occupational therapists asserted that it was a useful assessment that focused on service users' goals and measured progress of the service user. However, it was not integrated into the current paperwork required of the service and therefore not universally used.

The MOTOM (James and Corr, 2004) is a measure of occupational performance in daily occupations, for example 'difficulty getting out of the bath'. Each element is scored before and after intervention using a five point rating scale, with 1 representing being unable to complete an occupation to 5 representing independent with or without assistive devices or removal/reduction of risk. The median change in score represents the degree of change. Occupational therapists in Tollbury who used the MOTOM described the assessment as particularly important for those service users who did not achieve their identified goals in full, as the scoring system demonstrated change. The assessment enabled occupational therapists and support workers to illustrate service users' improvement during reablement:

'when I started they [support workers] only saw that people were independent or needed ongoing care. And now [support workers] can measure some kind of improvement that isn't moving to full independence. So I think that's useful'

(Clare, occupational therapist, Tollbury)

Results from standardised assessments helped to provide evidence of the effectiveness of reablement to present to commissioners of the reablement service:

'it helps to justify our existence...because you can see how much progress you make... You assess them as a two ... they can do maybe a little bit, but mostly people are not doing it for themselves. Then they might [meet their goal] then you've gone from a two to five. You know that you've made progress of three. Even if somebody hasn't [met their goal] you can

see that they have made progress...from a two to a three, or a three to a four. So it is useful for us to see that our interventions are making a difference' (Pete, occupational therapist, Tollbury).

When asked whether managers currently request statistical information on the reablement service, occupational therapists replied that they hadn't been asked for it 'yet'. The occupational therapists reasoned that statistics, such as whether service users had achieved their goals, provided evidence that the reablement service was effective. The nature of reablement and the role of occupational therapists was considered as not easily measured:

'It's not very easily measured and it's not very easy to observe either...I think a lot of reablement is a lot about how that person's wellbeing is, because I think it's more than just whether they can wash themselves in the morning, it's whether they're confident doing that, and whether they're going to do it, and whether they can continue to have quality of life after that, or whether it takes them three hours to wash and then they can't do anything for the rest of the day'
(Barb, occupational therapist, Averdale)

5.3.3 Goal setting

Assessment was considered as an important precursor, and integral, to goal setting as it enabled occupational therapists to understanding a service user's abilities and difficulties. Pete (occupational therapist, Tollbury) described goal setting as '*an affirmation of the whole assessment*'. Goal setting was asserted as a collaborative process between the service user and the occupational therapist. During observations occupational therapists asked open questions to introduce goal setting such as:

'let's have a chat about what you'd like to achieve...what's realistic?'
(Gill, Tollbury).

'it's just setting yourself some targets...something to aim for'
(Pete, Tollbury)

Occupational therapists supported the mechanism of being person centred in their thinking about writing goals. There was a recognition that service users' identified

goals and the goals that occupational therapists identify as important, may be different.

'keep asking the person what their priorities are...what they think is important is not what you think is important and I think...it's definitely our role to make sure that we're listening to them and we're not just imparting our thoughts on them and it might not be what they want to focus on'. (Jane, occupational therapist, Averdale)

An observation of Clare on a home visit confirmed the comments on the importance of listening to service users' views when she said:

'If you are happy with what is happening with meals then we won't set a goal for that.' (Clare, Tollbury).

Setting goals that were important to the service user sometimes resulted in small goals, for example a service user being able to wash their own face. Occupational therapists sought to meet service users' goals at different levels:

'I could equally take as much joy in....someone being able to wash one cheek with their flannel. Than I could with someone achieving full independence' (Angela, Foybrook)

5.3.3.1 Setting person centred goals – a learned skill

In Foybrook the Local Authority manager emphasised the ability to grade goals as a core skill of occupational therapists. In their service the occupational therapists had taken the lead in training other professionals in writing and evaluating goals. Senior practitioners checked goals to ensure they were clear and measurable, to support the greatest potential for achievement by the service users.

Focusing on service user's goals was considered a skill to learn. Some occupational therapists had sought further training to identify goals. Pete (occupational therapist, Tollbury) spoke of his journey of improvement in setting goals:

'I'm getting better at setting goals. I was never very good to start with because we just went in and said 'oh they need to wash and dress and needs help to do that' (Pete, Tollbury)

Occupational therapists newer to working in reablement spoke about identifying service users' difficulties and suggesting ways a service user could do more for themselves. This has been described as taking a procedural clinical reasoning approach (discussed further in the following chapter) in which occupational therapists identify a problem, set a goal and decide a treatment plan (Fleming, 1991). This approach focusses on the knowledge and experience of occupational therapists, with less focus on what is important for the service user.

5.3.3.2 'No person is an island'

Hannah, (occupational therapist, Averdale) coined the phrase '*no person is an island*' when talking about working with a service user's family. Families were seen as an essential part of the service user's network and therefore occupational therapists sought to support family members with information, advice, equipment and demonstration of techniques to assist them in their caring role.

Hannah described working with a daughter whose father was being discharged from hospital to live with her for the final few weeks of his life. She considered that her discussion on likely progression of her father and her provision and demonstration of equipment and techniques, enabled the daughter to care for her father at home until he died.

In Tollbury, occupational therapist Clare shared her experience of working with a family in which the daughter, Geraldine, was caring for her mother, Isabel, who had had a stroke. Geraldine advised that she was finding it very difficult to care for Isabel. Isabel and Geraldine had understood that Isabel should mainly sit in a chair to reduce the risk of having another stroke. When Clare asked Isabel if she would make her a cup of tea, she was able to do so, but said "I didn't know I was allowed to make a cup of tea". Clare worked with Isabel on how she could do more for herself and educated Geraldine on the reablement ethos. Geraldine had felt that she had to do everything for her mother and Clare quoted Geraldine reporting that it was '*a huge relief*' when she realised she did not have to do everything for her mother.

The advice and support given to families by occupational therapists as part of the reablement service enabled families to support service users themselves. This

reduced the need for support either from support workers from the reablement service or longer term support from domiciliary care services.

5.3.3.3 Mechanism of safety

An underlying mechanism that did not arise from the literature in the realist synthesis was safety. Occupational therapists all asserted that their practice was based on service users' goals. In addition to service user's goals occupational therapists also considered safety as a key element of their role:

'So ultimately I feel that I'm partly responsible for keeping somebody safe in their home. So that's my primary objective when I go into anybody's home for the first time; making sure they are safely able to do what they need to do' (Hannah, Averdale)

Occupational therapists' focus on safety could also complicate the writing of goals:

'it's really hard to put it in a box and quantify it if you're just thinking somebody generally needs to be safer when they're transferring. But I try and say to them..in real terms what it means for them. So 'I want you to be able to get up out of your chair safely'. But then actually they won't realise that's their goal unless you say 'I'm going to write this down as a goal' (Jane, Averdale)

The beginning of the goal 'I want you to be able...' is written from the perspective of the occupational therapist rather than being a person centred goal. Jane had worked for the reablement team for less than a year. If the service user doesn't recognise the goal they may not be motivated to work on that goal (service user motivation is explored further below, section 5.8.5).

Trust as an underlying mechanism (again presented in more detail in section 5.3.3.4 below) was evident between support workers and occupational therapists particularly in the area of service user safety. When asked how they would explain the role of occupational therapists to service users, participants in one Averdale focus group said: *'make them safe in their own environment'* (Matt and Suzie, support workers, Averdale).

The importance of safety was echoed in the second focus group in Averdale. Support worker, Sandra, asserted that occupational therapists provided equipment both to support service users to be independent and to ensure their safety. The manager of the independent organisation confirmed their trust in occupational therapists to support them to engage in safe and the least intrusive practice:

'I suppose for us it's more about safe working because without them [occupational therapists] sometimes we would be a little bit unsure on how to move forward safely.' (Carolyn, manager, Averdale).

Safety was clearly an important consideration for occupational therapists, support workers and the independent organisation managers. This has potential implications for working in a person centred way if service users do not agree with occupational therapists' recommendations and goals that relate to safety. They may, for example, wish to take more risks in being supported to move around their home, which may increase risk to support workers. However, during observations and discussions with occupational therapists in this study no disagreements were evident.

5.3.3.4 Establishing rapport and gaining trust

Establishing rapport and gaining the trust of service users was deemed important in setting person centred goals.

'it can be quite a lengthy process and I tend to not necessarily do it all in the first instance either ...I prefer to build up a little bit of a relationship and work on those goals over a couple of visits. Once they get to know you they're much more likely to tell you what they want as well. It doesn't work if you're trying to force goals on people for the sake of goals because you don't get that interaction. Some people are just very used to being told what to do, but for most people they won't engage in the process if it's not something that means something to them.'

(Zoe, occupational therapist Averdale)

Some service users needed more support and prompting than others to set goals. Observing a visit with Gill (occupational therapist, Tollbury) provided an example of collaborative working to agree a goal. Service user, Yvonne, had difficulty

articulating what she found difficult. Gill suggested that Yvonne showed her how she managed around the home. Yvonne experienced breathlessness and was unable to step into her shower and stated that she did not want to be able to do this. She said that she was happy strip washing. There was a significant body odour and urine smell in the house that Gill did not discuss with Yvonne during the visit. Gill commented on how strong the smell was and how Yvonne must be finding personal care difficult, during a discussion of the visit on the journey back to the office. During the visit Gill offered support from the reablement support workers to help Yvonne wash and dress and Yvonne agreed. The goal agreed at the end of the visit was written as 'to enable [Yvonne] to wash and dress.'

5.3.3.5 Realistic goals

Occupational therapists spoke of establishing a balance between what service users wanted to achieve and how those goals could be met with support from the reablement service. Occupational therapists highlighted their role to support people to break down larger goals into smaller realistic goals. This was evidenced in an observation of Zoe undertaking a first visit to a service user recently discharged from hospital. The following vignette is taken from my observations notes of the visit and a reflective discussion of the visit with Zoe following the visit and also followed up in her interview.

The service user, Esther, was admitted to hospital following a fall at home. It was found that she had cancer. As her condition deteriorated Esther was no longer able to walk and required a hoist to move in and out of bed. Esther had been in bed for a considerable time and there were concerns about her skin and posture. Both these factors affected her ability to sit out in a chair for significant periods of time.

During the visit Esther and her husband explained that their goal was to go away for the weekend. The occupational therapist (Zoe) listened to the goal of the family and agreed to return the next day to discuss it further. Following the visit I asked Zoe about the goal the family wanted to achieve. Zoe expressed concern about writing down the goal of going away for the weekend, as she was not able to ascertain whether it was achievable. During her interview I asked Zoe how she would respond to Esther's goal. She said that she would speak to Esther in a conversation such as this:

'OK so that's a massive goalWe need to start with realistically being able to sit out of bed for the amount of time it would take to get to your holiday destination'

She continued with her thoughts about setting smaller, realistic goals:

....you want to break it down so that they can see 'oh if I'm not even achieving that perhaps that is unrealistic'. Or they might achieve everything at break neck speed and then you might be able to achieve their big goal but it's breaking it down.. to make sure that they understand all the components of a big goal like that' (Zoe, Averdale)

Zoe explained that whilst sitting in a chair for five hours would not have a sense of meaning for many service users; in this case it represented the possibility of going on holiday, a tangible event.

Vignette 2 Setting goals with Esther

5.3.4 Influence of team policy/manager perspective

Occupational therapists identified organisational contexts that reduced their ability to be person centred and work on all the goals of service users. One described what they were able to work on as *'the absolute basics'* (Pete, occupational therapist, Tollbury). These 'basics' were largely described as personal

care, mobilising around the home and kitchen skills. This was confirmed in an interview with a reablement manager who said:

'we can only fix the basics and then we need to let them move on'
(Emily, Manager, Averdale).

The majority of goals agreed during observation visits were related to personal care. Occupational therapists expressed views that they had both the skills and willingness to work with service users on wider goals such as enabling someone to go shopping or accompanying service users to clubs in the community to build the service user's confidence. They felt that they were constrained by the remit of the service. To manage the constraints, one occupational therapist sought to manage the expectations of service users by the provision of information, using the phrase:

'this is what we can help you with' (Zoe, Averdale)

During observations there was evidence that some occupational therapists identified wider goals with service users. Pete (Tollbury) gave an example of providing advice for a service user to meet a goal himself:

'he loved gardening but his mobility got to the stage where he wasn't able to bend down and do things so we talked [about] having raised planters in his garden..that he would be able to organise and still grow vegetables even if he ended up in a wheelchair.' (Pete, Tollbury)

At the level of teams, managers highlighted negative aspects of occupational therapists being person centred. Emily (Manager, Averdale) felt that as empathic practitioners, occupational therapists often took responsibility for aspects outside of the remit of the service, particularly if service users were in crisis situations. This was confirmed in a comment by Hannah in Averdale saying she found it *'hard to let go'* and wanted to *'look after'* service users.

To support the mechanism of being person centred within the context of reducing budgets, occupational therapists in Foybrook attempted to identify support from the wider community to meet needs. For example if someone was having difficulty shopping occupational therapists might suggest online shopping or community volunteers to possibly meet the goal.

5.4 Programme theory 3 – using a toolbox of interventions

The third programme theory for testing in the data collection phase (box 9) was very specific to the task of providing equipment for service users and carers.

The timely provision of equipment increases the independence of service users and supports carers in their caring role.

Box 9 Programme theory three - provision of equipment

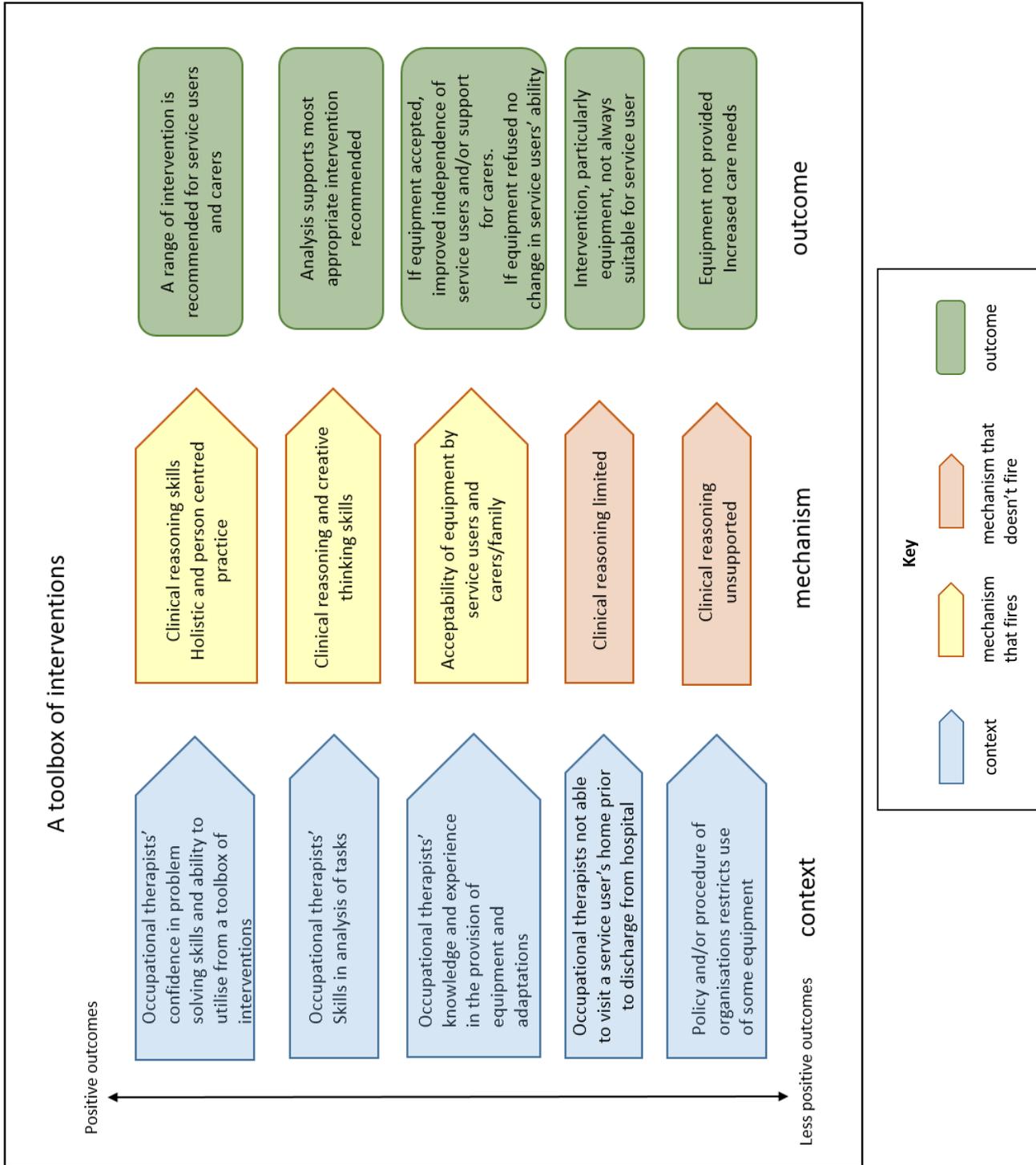
Research participants in all of the case studies recognised the role of assessing for and providing equipment in the reablement setting. Equipment was provided as an option within a toolbox of interventions, reflected in the title of the expanded programme theory. The contexts, mechanisms outcome configurations identified during data collection are presented in figure 10. Occupational therapists described themselves as problem solvers. Assessments, as previously described, were key to establishing and analysing difficulties. This analysis determined the approach taken by occupational therapists; utilising their tool box of interventions. The toolbox included providing information and advice on techniques, working on routines and providing equipment.

5.4.1 Occupational therapists as respected members of the team

Occupational therapists and their managers identified problem solving skills as essential skills of occupational therapists working in reablement settings. One occupational therapist asserted that the problem solving skills of occupational therapists were respected by other members of her team:

‘I definitely feel like a real respected member of the team. I think there is a recognition that there’s a problem with technique, there’s a problem with environment, there’s just a general problem and nobody else quite knows what to do so ‘OTs know everything’. So I think there is a lot more respect for the OT profession.’ (Hannah, Averdale)

Figure 10 CMO configurations - toolbox of interventions



5.4.2 Analysing difficulties

Assessing service users by analysing difficulties was a reasoning process to make decisions on the most suitable support for service users:

'assess the situation, think laterally, think logically and break and grade everything down and work out when equipment might be suitable to use, when we need to change technique or a system of work'

(Chloe, occupational therapist, Foybrook)

This approach of analysing the situation was considered as a core skill of occupational therapy and different from that of other colleagues in the teams; and different from traditional models of home care. Occupational therapists were using their clinical reasoning skills to analyse the situation.

'Rather than just saying somebody's having difficulty getting washed and dressed, actually what bit is it that's the difficulty; and actually breaking that down to then work out "OK..., it's because actually your standing tolerance is reduced"...It's really taking that deeper analysis and I think as OTs we are able to then really break that down into the ...lowest denominator to then say "well actually now we know what the difficulty is, what are the options that we've got?"

(Angela, occupational therapist, Foybrook)

'the OTs have quite a lot of skills in terms of thinking out of the box and in terms of 'how can we provide something differently?' The problem solving bit of itrequires quite a lot of creative thinking about how things are going to be done and just challenging really the traditional models of how home care used to be put in' (June, Manager, Foybrook).

In Foybrook, senior members of the team checked reablement plans before they were sent to the independent organisation. Chloe (Foybrook) provided an example of a social worker who was requesting support of two support workers for a service user at home; no equipment had been considered. An occupational therapist was asked visit to assess for equipment that may reduce the need for two carers to assist a person.

Unique to service users being discharged from hospital, volume of work sometimes prevented occupational therapists from completing home visits with service users prior to discharge from hospital. This could lead to a poorer outcome for the service user. When home visits were not completed the occupational therapists' opportunity to fully analyse situations was reduced. Support workers in Averdale raised the issue that it was not always possible to use equipment that occupational therapists had ordered for service users due to lack of space.

Similarly support workers in Foybrook, on the first visit to a service user following a hospital discharge, relayed situations where they discovered that the service user's gas or water was switched off or there was an excessive amount of belongings. These issues presented additional risks to support workers and the service user. If occupational therapists were unable to visit the service users' homes they experienced a reduced ability to use their clinical reasoning skills to make decisions on appropriate equipment and support.

5.4.3 The knowledge bank and the occupational therapy tool box

Occupational therapists described using their training and experience as their 'knowledge bank', alongside a 'tool box' of options; to decide on the intervention that would support service users to meet their goals. The occupational therapists' 'tool box' included therapeutic input, information and advice, demonstration of different techniques and knowledge and provision of equipment and adaptations. Knowledge of medical conditions, experience of working as occupational therapists in other settings, and life experience were all highlighted as contexts that supported an ability to utilise a 'knowledge bank'.

5.4.3.1 Information and advice

During home visits to service users occupational therapists assessed needs, analysed those needs and provided suggestions to meet needs within the same visit. This included providing information and advice and suggesting alternative techniques. As an example, during a visit to a service user, occupational therapist Grace in Foybrook observed a service user getting out of bed. She advised on a method to enable the service user to sit up in bed by himself as an alternative to the observed method of using his wife to support him. Intervention during home

visits also included recommending small items of equipment such as long handled reachers and sock aids; or minor environmental changes, for example, moving a bed to accommodate a commode.

During observations it was evident that occupational therapists held a lot of information about other services such as NHS assessment teams, occupational therapists in the wider social care team, falls service and bereavement groups. Occupational therapists provided advice and guidance during home visits on a range of topics including: the benefits of using the stairs as cardiac exercise; building up sitting tolerance; how to apply for disability benefits to fund assistance with gardening and cleaning; and guidance on best practice of how to move an arm following an arm fracture. Occupational therapists identified their experience in working with older people; knowledge of orthopaedics, infections, dementia; and knowledge of the law, as topics that were useful for practice in reablement. One occupational therapist who had worked for the reablement service for less than a year recognised that her lack of knowledge in some areas was a hindrance to her practice.

Several occupational therapists had visited other services as part of their induction and training programme and asserted that this increased their knowledge of different services enabling them to provide better advice and make appropriate referrals. Co-location of different teams supported communication of advice between colleagues in a timely way; as a preference to making a formal referral to that team. In Averdale it was also suggested that this reduced the number of referrals between the teams.

5.4.4 (Re)establishing routines

Following analysis of difficulties occupational therapists shared several examples of working with service users to establish or re-establish routines that used several features of the occupational therapists' toolkit. The following vignettes, summarised from interview transcripts with occupational therapists, provide examples of establishing routines.

Donna, had had an extended stay in hospital, and was experiencing high levels of pain, following an ankle injury. A physiotherapist in the reablement team was working with Donna on building her muscle strength and mobility of her ankle. Jane (occupational therapist, Averdale) worked with Donna on techniques to get in and out of the bath. Donna hadn't made herself meals for a long time and opted to heat up meals in the microwave. She purchased her first microwave but had difficulty using the timer. Jane supported Donna to purchase meals that had the same cooking duration time and affixed stickers under the numbers on the microwave that Donna needed to use most often. This simplification of the daily occupation of cooking for the service user supported her to establish a new routine.

Vignette 3 Supporting Donna to manage her meals

Dorothy was admitted to hospital following a fall. During planning of Dorothy's discharge from hospital Occupational therapist, Grace (Foybrook), discovered that Dorothy's house was very dirty. Her heating was broken and some features in the house needed fixing.

Grace emphasised that she used equipment for the bath as a means of developing a relationship with Dorothy. Dorothy was reluctant to accept support and the equipment was provided at no cost to her. Grace was able to arrange for some repairs in the home. The period of reablement provided time for the support workers to work with Dorothy on what Grace described as '*establishing a working method*' or routine with domestic tasks in the home. Following a period of intervention Dorothy continued to have two visits per week as a preventative measure. The ongoing support aimed to prevent Dorothy returning to her previous situation. Dorothy was pleased with the outcome of reablement, quoting that she had '*got her mojo back*' and that support from the reablement service helped her to recognise her problem as she '*couldn't see the wood for the trees*'. Dorothy continued to do more for herself starting with going for a walk outside.

Vignette 4 Supporting Dorothy with a cleaning routine

In both of the above scenarios support workers worked with service users and occupational therapists on establishing routines. On another occasion the contextual influence of the policies of the independent organisations did not

support the mechanism of supporting routines. Clare (occupational therapist, Tollbury) described working with Marjorie who had been supported by the reablement service to dress herself independently and was working on preparing her own meals. The support workers fed back to Clare that Marjorie ‘would not wash’. Clare visited Marjorie and established that she always showered in the evening and had done so for many years. Clare asked the independent organisation to support Marjorie with gaining confidence in the shower, in the evening. The support worker organisation declined the request citing that ‘person care is [undertaken] in the morning’. In order to arrange for support with showering to occur in the evening Clare had to discuss her reasoning for the request with her manager before the independent organisation agreed. Clare described the situation as a battle that she ‘won’.

5.4.5 Provision of equipment

Occupational therapists in all case studies provided equipment as part of their ‘tool box’ of interventions. During observations, occupational therapists offered a variety of equipment including rails, a key safe, perching stools, commodes, hoists, bathlifts and glide sheets for moving and handling. Equipment was provided to meet service users’ goals and increase the independence of service users. Barb (occupational therapist, Averdale) provided an example of using equipment alongside adapting the environment to support a service user to be independent and reduce her level of support:

‘So it was really important that she could get in and out of bed on her own. So we looked at the environment .. it was a very small annex so, [we] needed to move furniture around a bit to give her more space. Put in some equipment, such as a bed lever....her evening visits ended within a couple of days’ (Barb, Averdale)

Occupational therapists considered the provision of equipment as a key element of their role; but not the only element. A number of occupational therapists commented on their experience of workers in other teams perceiving occupational therapists as primarily providers of equipment. This comment was explored during interviews and focus groups with support workers with the question ‘if you had to explain to a service user what occupational therapists do, what would you say?’.

Support workers in Foybrook recognised occupational therapists as providers of equipment. In one focus group in Averdale the first response to the question was:

'[to] assess them for equipment that they might need to support them with their independence. So they're safe'

(Sandra, support worker, Averdale)

The second response was:

'learn new techniques, show them new techniques'

(Wendy, support worker, Averdale)

Equipment was clearly cited as an example of when support workers have contact with occupational therapists. Support workers also recognised a wider remit for occupational therapists as providers of advice on techniques to support service users to be safe and more independent.

5.4.5.1 Range of equipment available

The majority of equipment provided to service users by occupational therapists during observations, and discussed during interviews, was not complex or specialist equipment. Grace (occupational therapist, Foybrook) described the positive affect that providing a small item had on the service user:

'one of the biggest successes I made was just putting a little marker, a Bumpon thing on the entry phone and she could answer the door herself'

(Grace, Foybrook)

Occupational therapists had access to a different range of equipment in each of the case studies. In Foybrook occupational therapists were able to order any equipment available from a standard stock of equipment and could also arrange for minor and major adaptations. In Tollbury occupational therapist, Clare, confirmed they she had access to *'most of the equipment I need'* but was not able to provide chairs. Similarly in Averdale occupational therapists had access to a range of standard stock for delivery from their equipment store. Occupational therapists in Tollbury were not able to order what they described as small items of equipment such as sock aids and reachers. They advised service users how they could purchase these items themselves. In Averdale occupational therapists could order small

items of equipment for service users and asserted that the cost of these small items needed to be compared with the cost of ongoing care. One occupational therapist commented:

'with reablementequipment needs to be looked at in a different way... providing those small aids when you look at the cost of them having a morning visit... Actually it's much more beneficial reablement changes the way that I think equipment gets looked at in the budget; because you need to compare it to the package of care (Barb, Averdale)

Whilst small items could be provided, occupational therapists in Averdale highlighted difficulties in providing equipment that they assessed as beneficial for service users, but was not within the standard stock range of equipment. Applying for equipment outside of the standard stock involved making a special request for funding. The request had to include information on reasoning and costs for the equipment being requested. This process was generally explained as being a long process that led to a delay to the reablement process:

'having to wait for specialist equipment and those kinds of processes can be slower than the way that we work. So that can mean that we have people on our caseload for a long time when if they had that equipment in at the beginning we could have discharged them'. (Barb, Averdale)

The request to purchase items of equipment outside of the standard stock of equipment was described by one occupational therapist as a 'battle' (Hannah, Averdale). Before a special request could be made, occupational therapists were expected to try the equipment with service users and this could raise the service user's expectation. Occupational therapists needed to manage these expectations as messengers of the decision on whether equipment would be provided. Zoe (occupational therapist, Averdale) described this scenario:

'I had a couple of ladies and I got the Mangar rep with the inflatable leg lifter and you had to try it with the service user before you put in a request. For both of them it worked really nicely, but then I had to go through and make a special request; and the request took about three months for a decision to come back to me. Because of funding they have

to look into it and analyse it and that was quite limiting. Those two ladies stayed on my caseload whilst I was waiting this decision. Again, managing expectations. Those ladies have seen how wonderful this bit of equipment is and they are waiting 'will I or won't I?' and then to find out that they won't get it is...you know, you feel quite bad to go back and say 'well actually no, you're not getting that' (Zoe, Averdale)

5.4.5.2 Equipment was not always successful

The provision of equipment was not always a successful intervention. An occupational therapist who had worked for the reablement team for less than a year commented about equipment:

'I think that we like the idea of it, but quite often it doesn't quite fit the mould. There's been a few occasions where I've wanted a piece of equipment to work and it hasn't quite and I've had to go for a simpler option'. (Jane, Averdale)

Jane explained that she was reflecting on a recent experience with a service user. During an observed home visit, Jane had set up an alarm prompt using an item of telecare equipment for the service user. Following the visit the service user contacted Jane to say that he did not wish to keep the equipment. Jane reasoned that the equipment provided was not necessary to meet the service user's needs, she explained:

'they have financial concerns they weren't really expressing in the beginning and we realised that actually the person could do with some other form of external prompt. It could just be an alarm on a phone. So we're gonna go down that route first just to see if that's enough for them because they are able to read. So they don't need the spoken word that the telecare provides'. (Jane, Averdale).

5.4.5.3 View of equipment by service users

Occupational therapists were observed explaining the benefits of the equipment they were suggesting and answering a range of questions from service users and family members on the design and fitting of equipment and who would pay for it.

There was evidence of service users benefitting from equipment during home visits. During an observed home visit the service user said that the rail Barb (occupational therapist, Averdale) had provided on the bed was *'the best thing ever'* as it enabled her to get out of bed more easily. During a home visit with Zoe, also in Averdale, to review the fitting of some rails the service user commented that she *'couldn't do without them'*.

A number of support workers who had worked with the same service user recalled the positive effect that equipment had had on the service user's emotional wellbeing and ability to carry out other tasks:

'An occupational therapist gave a service user a pedal bicycle thing ...And that really helped him. His mobility wasn't very good. He spent all his day pretty much sitting in a chair in the sitting room and when they gave him this it was an absolute lifeline and it really built up his strength ... he really enjoyed it because it gave him something to do'.

(Liz, support worker, Averdale)

'He also imagined he was going on little journeys'.

(Sandra, support worker, Averdale)

'when we got up to use the loo he was stronger every time because he'd built up his strength and his leg muscles' (Liz, support worker, Averdale)

Support workers in another focus group in Averdale asserted that service users did not always readily accept equipment provided by occupational therapists or physiotherapists, particularly mobility aids. Support worker, Matt, linked the acceptability of equipment with image:

'they're embarrassed to be seen with something they've never used before... "what's people going to think about me"'

(Matt, support worker, Averdale)

The support workers shared their experience that service users generally accepted using equipment within their own homes. This is the environment in which the majority of equipment provided by occupational therapists is likely to be located, to support service users to undertake daily occupations. Family members were considered to influence the acceptability of equipment. Suzy and Matt reported:

‘..unless of course they’ve got a partner. I’ve come across them putting toilet raisers in, and the partner is using the same bathroom and it’s a different height because maybe one’s tall and one’s short. Then they move it, or they don’t put it back, or they don’t like it; and you go and they’ve taken it out’ (Suzy, support worker, Averdale)

*‘I had someone once “my husband would hate that so I’m not having it”, but the fact is the lady couldn’t get off the toilet’
(Matt, support worker, Averdale)*

Occupational therapists proposed that the context of equipment being no cost to the service user was a factor in service users generally accepting equipment. To increase the probability of service users accepting equipment, one occupational therapist’s approach was to emphasise that service users only needed to keep the equipment as long as they needed it. She commented that:

‘people are usually accepting of that and they like the idea that that can be a marker for them getting better as well’ (Jane, Averdale).

Hannah (occupational therapist, Averdale) also promoted the concept of service users trying equipment for a short time. During a home visit to a service user recently discharged from hospital Hannah offered a commode for the service user to use at night, suggesting that she tried it for a few days and then it could be taken away if she did not want it.

5.4.6 Considering the needs of carers

Occupational therapists considered the needs of carers when working with service users and this included providing equipment to support carers. Justin was cared for by his wife with many tasks including getting in and out of bed into a wheelchair. Justin was unable to sit up by himself. During a home visit Hannah (Averdale) discussed and agreed to provide a ‘hospital bed’ that had a rise feature at the head of the bed to sit someone up. This type of bed is also height adjustable to enable the bed to be raised or lowered according to the tasks being undertaken. Hannah discussed that the bed could be raised when the carer was supporting Justin in bed to reduce the need for her to lean over and potentially cause injury to her back.

5.5 Programme theory 4 – occupational therapists and support workers

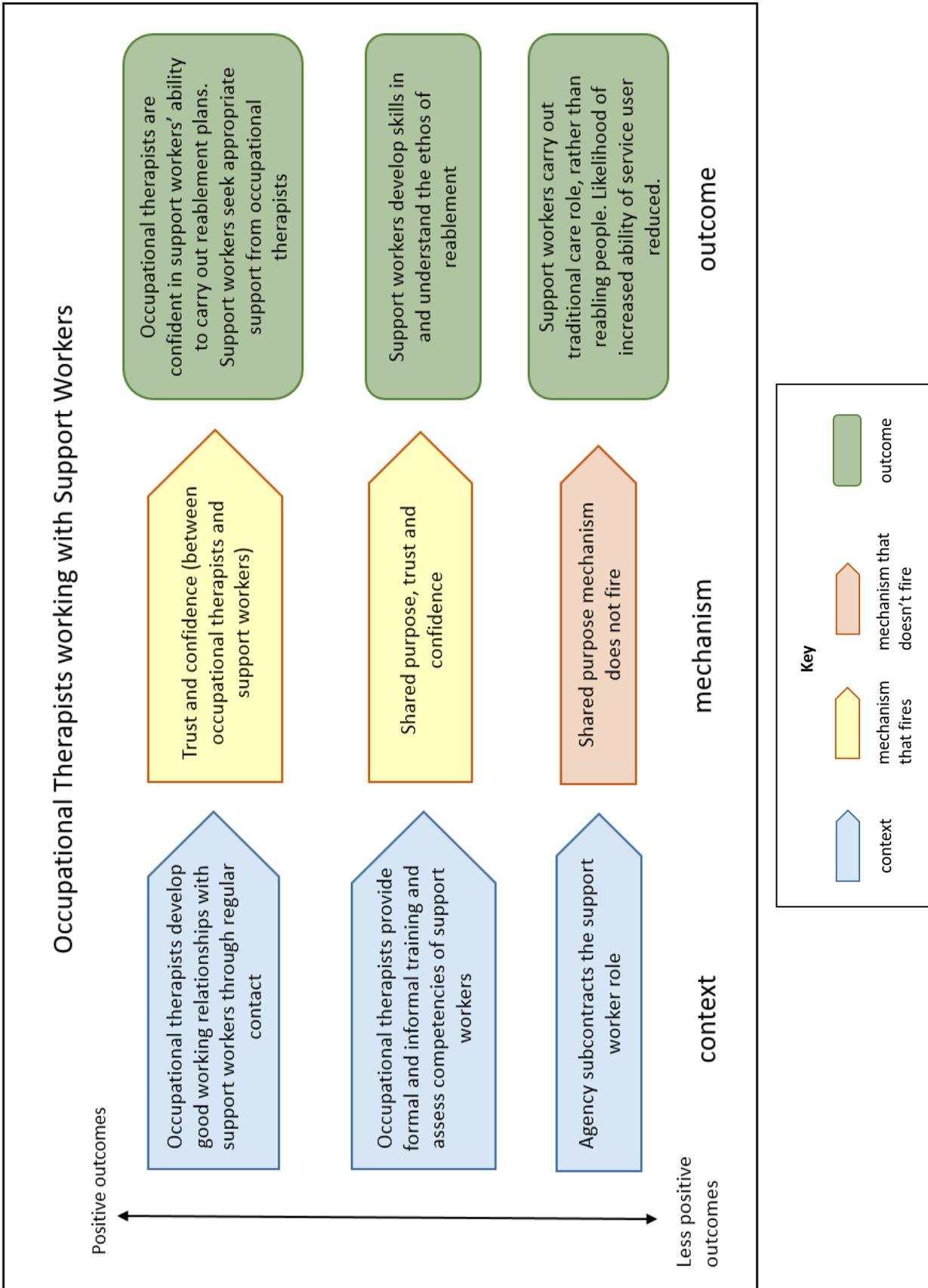
In each of the case studies, support workers were the members of the reablement team that spent the highest proportion of time with service users, working with them on their reablement plans. Occupational therapists worked closely with support workers, provided training and assessed support workers' competencies, confirming aspects of the programme theory (box 10).

Occupational therapists contact with support workers, including involvement in training, increases the skills and confidence of support workers and assists support workers to work in a reabling way.

Box 10 Programme theory four -oOccupational therapists and support workers

The contexts of training and regular contact triggered the mechanism of trust. This led to the outcomes of support workers developing skills in reablement and occupational therapists trusting support workers to work in a reabling way. The context mechanism outcome configurations developed from the data are presented in figure 11.

Figure 11 CMO configurations - occupational therapists and support workers



5.5.1 Trust in ability of support workers to reable

Support workers were seen as essential to the reablement service. They were described by Hannah (occupational therapist, Averdale) as *'our extra eyes and ears, invaluable really'*

Occupational therapists communicated different levels of guidance to support workers according to the complexity of the need. Emma (occupational therapist, Foybrook) advised that if she wrote an overall goal such as *'to walk by themselves using a walking stick'* she would provide suggestions to support workers on how to meet the goal. These suggestions included encouraging the use of equipment and using pacing techniques. Emma was confident that the support workers would be able to follow the suggestions to meet the goal making the comment *'it should be pretty bread and butter stuff [for them] by now'*.

Interviews with support workers in Foybrook confirmed that they used the goals and suggestions on reablement plans to work day-to-day with service users. Gill (occupational therapist, Tollbury) explained that if a service user had a specific moving and handling plan, then they would write instructions for support workers to follow. Conversely, no instructions were needed for reablement plans consisting of washing and dressing as Gill was confident that support workers were able to undertake these tasks following their training in the reablement approach.

The employment of support workers in Averdale was different from the other two case studies. Support workers were employed by the independent organisation, in the same manner as Tollbury and Foybrook. Averdale also employed support workers directly to the health and social care organisation. Occupational therapists had more frequent contact with the support workers employed by their own organisation. They were involved in the training and assessment of competencies of the support workers in their own team. One occupational therapist described the competency training as demonstrating the equipment, teaching the support workers how to adjust the equipment and then observing the support workers fitting and using the equipment on a number of occasions to *'make sure they are using them properly'* (Hannah, Averdale). The occupational therapists in Averdale were confident in the support workers' abilities, and had a high level of trust in their reablement skills and their ability to deliver and fit equipment for service

users. This was evidenced following a visit to a new service user to reablement (Harriet) with occupational therapist, Zoe. The following vignette is taken from my observation notes of the visit.

Harriet, was having difficulty getting out of bed and Zoe recommended a bed lever. Harriet agreed to try it. Following the visit Zoe telephoned the office from the car and arranged for a support worker to deliver and fit a bed lever for Harriet. Zoe explained that she asked the support worker to fit the bed lever and demonstrate it with Harriet as the bed was a standard type and the service user did not have any cognitive impairment. It was therefore straightforward and within the support workers competency level.

Vignette 5 Confidence in support workers

Occupational therapists identified a context that affected the delivery of reablement. If the independent organisation were short of staff they were able to subcontract work to a domiciliary care agency. Support workers with the other agency were not trained in reablement and therefore service users did not receive support with a reablement ethos. The mechanism of trust between occupational therapists and support workers also did not fire as occupational therapists received little feedback from the subcontracted agency.

5.5.2 Training support workers

Occupational therapists were involved in the training of support workers to a greater or lesser extent in each of the case studies. In Foybrook occupational therapists trained support workers during the development of the service to develop skills in enabling people rather than 'doing for' people:

'... It was a new service and to change that thought processes that you're not going in to do, you are going in to enable somebody else to do as much as they possibly can, that was a really steep learning curve... we set up some training sessions jointly with our practitioners, because for lots of them, as well, from a social care perspective that transition... of going in there with a compensatory approach before you even start... Rather than jumping to "somebody's having difficulty getting on and off the toilet, I'm going to provide you with a 4 inch raised toilet seat". It's

that sandwich in the middle. It's evidence based practice, which by doing the joint training with [name of organisation] and our practitioners we felt that they were working together'

(Angela, occupational therapist, Foybrook)

Angela concurred with other therapists acknowledging that the process of 'breaking things down' to enable people to do more for themselves was a long process; particularly for support workers who had previously worked as carers in a traditional role, where they often had a set amount of time to complete stated tasks.

Occupational therapists identified techniques essential for support workers in reablement services. Hannah (occupational therapist, Averdale) suggested dressing techniques, preservation of stamina and pacing techniques as specific areas that occupational therapists should train support workers in. The provision and use of equipment was also a main topic of training for support workers by occupational therapists.

5.5.2.1 Support workers, service users and equipment

In Tollbury and Averdale occupational therapists were involved in the training of support workers on basic equipment such as raised toilet seats, commodes, chair raisers and rails. Occupational therapists in Foybrook advised that they expected the support workers to know how to use a range of equipment as a result of training from their own organisation. Occupational therapists only demonstrated unique equipment to senior members of staff, and expected them to cascade that knowledge. In Foybrook it was evident that occupational therapists had a greater knowledge of equipment than the independent organisation. Joy (support worker, Foybrook) commented that the support workers were using equipment with service users that the moving and handling trainers in their organisation were not familiar with. Flynn, a support worker team leader in Foybrook, confirmed that the organisation was not able to train support workers on the entire range of equipment available. They relied on occupational therapists to demonstrate unfamiliar equipment they provided to service users, with the support workers visiting that person.

Support workers recognised their role with service users to practise using equipment that occupational therapists had provided. Support worker, Suzy (Averdale), asserted that most of the service users they work with were elderly, some with a memory impairment, so repetition was important to reinforce what occupational therapists had previously demonstrated. The support workers recalled conversations they have with service users such as:

‘what did the occupational therapist show you?..no that’s not what she showed you. This is how she showed you’.

(Suzy, support worker, Averdale)

There was evidence of support workers using the knowledge they’d gained to recognise when equipment might help service users and request equipment from occupational therapists. During an observation of a review meeting in Tollbury a support worker suggested that a service user would benefit from a height adjustable bed and a rail. The occupational therapist, Clare, agreed to visit the service user to establish whether this equipment would be of benefit.

Support workers in two of the case studies identified the context of delay in assessment for equipment by occupational therapists as affecting the support workers’ ability to support service users to be more independent. Support workers in the independent organisation in Averdale suggested that delays could be reduced if they were able to order basic equipment such as commodes and raised toilet seats. One support worker suggested:

‘if we were given the proper training on absolutely every single thing that you could purchase it would help...just to speed the process up’

(Liz, support worker, Averdale).

During the discussion about providing equipment support workers focused on knowing about all equipment rather than analysing the difficulty to identify possible equipment to meet the need.

Occupational therapists identified some concerns about support workers assessing for equipment. Gill (occupational therapist, Tollbury) cited examples of support workers offering equipment to service users that, following an assessment, was established to be not suitable for the service user. During observations of a review

meeting in Averdale, a message had been received from the independent organisation requesting a stand aid for a service user. During the meeting the allocated occupational therapist discussed with the team that this was not an appropriate piece of equipment for the service user as they were not able to weight bear, a condition of the use of stand aids. In this situation the occupational therapist agreed to speak to the independent organisation to discuss the situation.

5.5.3 Changes in training of support workers

In all case studies comprehensive levels of training had been implemented during the initial stages of the development of the reablement service. In Foybrook when the service began the occupational therapists worked closely with the support workers and were able to challenge their practice. For example if a visit was completed in a very short time (the example given was seven minutes) the occupational therapists may have challenged what the support worker was able to support the service user to achieve in that time.

During the time of data collection there was no ongoing joint training between the two organisations in Foybrook. The senior occupational therapist interviewed (Chloe) described how the occupational therapists were currently situated at the beginning of the process undertaking assessments and goal setting. She felt that occupational therapists would be better placed returning to working more closely with the support workers to support a reabling approach. Chloe suggested that a closer relationship with the support workers would provide a more consistent approach to translating the reablement plans; by discussing with the support workers how they should be supporting a person. Chloe asserted that the effectiveness of reablement was dependent on the support workers who worked with them. She said:

'there are some cases I look at and I think gosh they've done a fantastic piece of work here and I'm really, really impressed but that is really down to the individuals that have driven it there ... looking at their view of promoting independence and I think there is a bigger role for OT to expand and widen that as well'(Chloe, occupational therapist, Foybrook)

Support workers in Averdale who had been employed in the reablement service at the outset of the service spoke positively of a comprehensive training programme run by the occupational therapists and physiotherapists in the reablement service. In contrast to this, the newest support worker to the team was not aware of a formal training programme and advised that equipment was demonstrated to her with individual service users.

The occupational therapists were not involved in training or assessing the competencies of the support workers in the independent organisation in Averdale. Support workers in the independent organisation described attending a demonstration of equipment run by the equipment stores. They commented on the purpose of attending the training:

[so]‘we’re able to establish when we’re doing calls ‘well actually that could help’ (Stella, support worker, Averdale)

So that we’ve seen what’s available (Paula, support worker, Averdale)

Following this training the support workers advised that they could request equipment such as perching stools for service users and the occupational therapist will ‘usually provide it’, suggesting that occupational therapists trusted support workers’ judgement on suitable basic equipment.

5.6 New programme theories identified

The four programme theories identified from the realist synthesis review of the literature focussed on occupational therapists as members of the reablement team undertaking assessments, goal setting and reablement plans, providing equipment and working with support workers. Further context mechanism outcome configurations were identified from the research data that formulate into two additional programme theories. The first of the new programme theories, programme theory five, represents the team working approach across the two organisations in the reablement services. The second of the new programme theories, six, highlights the importance of ‘buy in’, or shared purpose, at all layers of reablement intervention.

5.7 Programme theory 5 – working as a team

This first new programme theory focusses on occupational therapists working within the reablement team (box 11).

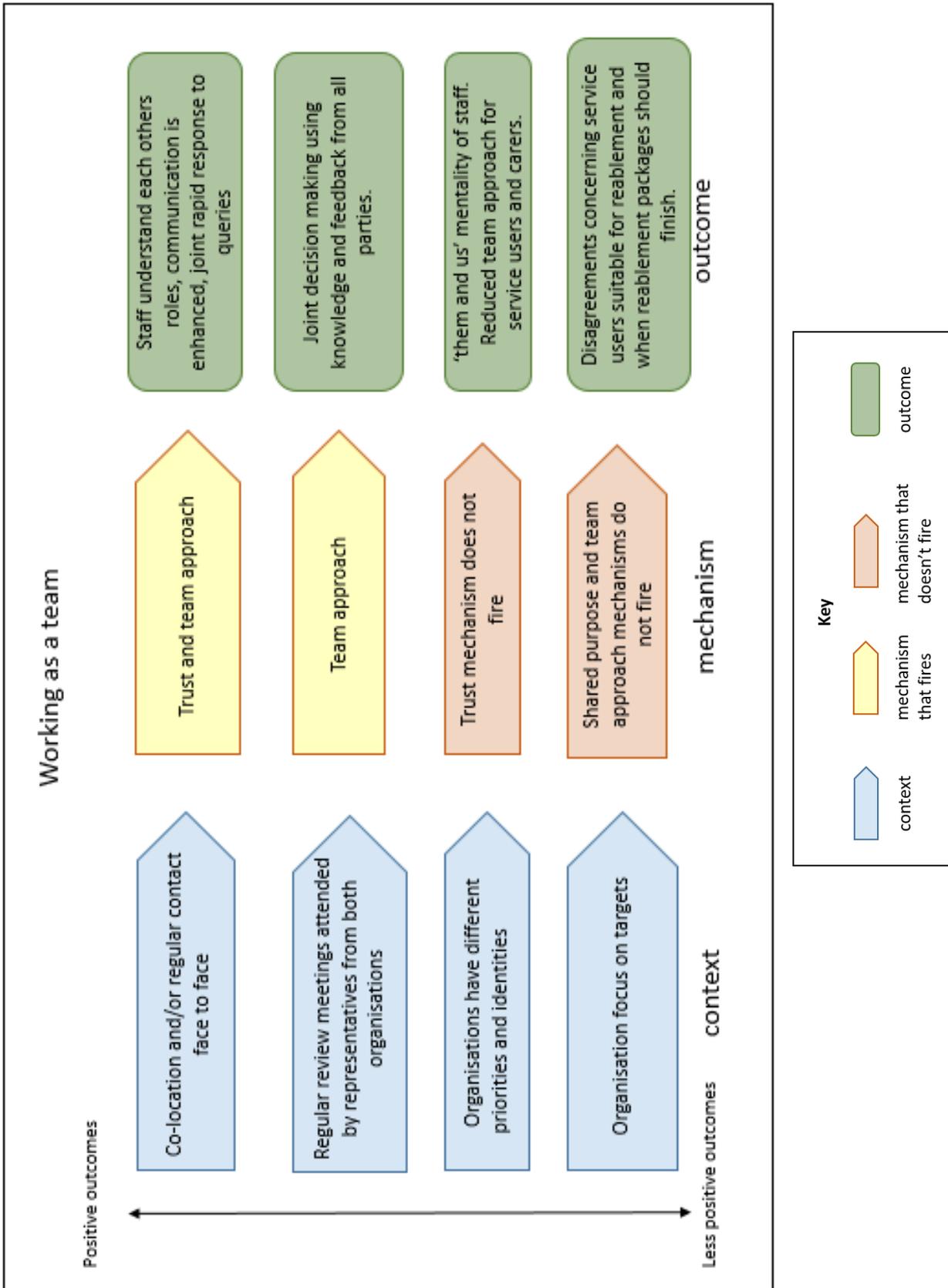
Regular face to face contact including co-location and regular meetings supports communication, encourages trust, a team approach and an understanding of one another's roles; and enables a joint approach to decision making.

Box 11 Programme theory five - working as a team

Contexts, mechanisms and outcomes were identified from the research data and formulated into the configurations in figure 12. Regular contact between staff in the two organisations, through contexts including co-location and regular meetings, supported a team approach and trust between staff; and led to a positive outcome for staff and service users. The different priorities of the two organisations did not support the mechanism of trust and taking a team approach. This led to less positive outcomes.

An example of a team approach was observed in Foybrook. Occupational therapists working with service users being discharged from hospital worked closely with social workers. If a social worker was the main worker with a service user and a need for input from an occupational therapist was identified then the occupational therapist would assist with that piece of work. In these cases the main worker would continue working with the service user demonstrating a team approach, utilising the unique skills of each staff member within the team.

Figure 12 CMO configurations - working as a team



In Tollbury and Averdale weekly meetings were held to discuss all the service users in the reablement service in their area. During observations of three of these meetings in Averdale, there was sense of a shared approach to working with service users. If support was needed from another person in the team such as an occupational therapist identifying a need for support from a physiotherapist, a worker would be allocated at that meeting. Whilst each service was allocated a lead professional, team members had an awareness of all the service users being supported by reablement through these regular meetings and through progress information written on an erasable board in the office. A context that may have necessitated this was the structure of the service as a seven day a week service. Occupational therapists working at the weekend would often visit service users who were not known to them. They described the meetings as an opportunity to receive recent feedback on the progress and difficulties of all the service users currently being supported by the service. Both the meetings and the erasable information board supported clear communication concerning service users.

5.7.1 Knowing your colleagues - working face to face

All reablement case studies were made up of two organisations. Communication and trust between the two organisations were identified by all participants as key to the success of reablement. Communication included assessment and goal setting paperwork, regular meetings and one to one communication between workers, by telephone and face to face.

Some reablement teams were co-located with other professionals and/or the independent organisations. Co-location supported sharing of information. For example, occupational therapists in Averdale were able to ask district nurses, who shared a space in their office, about the medical status of a service user or whether district nurses were currently visiting a service user. Co-location was asserted as encouraging communication and respect between different members of staff and promoting a team approach.

Co-location was a key factor that supported communication on an informal level. One occupational therapist compared working with the support workers in the independent organisation, who were located in a different office, with the support

workers co-located with the occupational therapists in the health and social care team:

'Purely because they don't work in the same environment and the same office as the therapists. So they don't have the same back and forth conversations. They're just not as well attuned. And although they are experienced carers and they do communicate with us I feel there's just something missing. There's that something that's just not quite there between...it still feels like there's a them and an us'

(Hannah, occupational therapist, Averdale)

In contrast in one area in Tollbury both organisations of the reablement service were located in the same building. Occupational therapists in this team said that they had a good relationship with the support workers who regularly came into the office to feedback about service users. Co-location was identified as being key to understanding.

'I feel as if I get on much better with the people that I've met face to face and they've seen me..because when you talk on the phone you can come across as being..a bit aggressive about something...and they think: 'I know this and this is how we do it' but then when they meet me and I go through things. We're now quite friendly and chatty and they get where I'm coming from' (Gill, occupational therapist, Tollbury).

During observations in the office environment in Tollbury, the manager of the independent organisation visited the occupational therapist several times. Visits were typically brief, under five minutes, and focussed on discussion concerning individual service users. Advice was given and actions decided quickly following this easily accessible, one to one contact.

5.7.2 Communication and trust

Communication was highlighted as particularly important during the initial stages of the development of the reablement service:

'The first six to eight months was rocky as it would be with any multi agencies working together and trying to iron it all out. There was a little

bit of confusion but generally now I think we're working quite well. They just have that open communication. They know who they're talking to, who they're going to. Who to ask the questions of. So that works really well, especially going there and being able to work out of their offices which we...we don't so much, but we can if we need to'

(Carolyn, Manager of independent organisation, Averdale)

Limited contact and poor communication between organisations did not support a team approach; staff had less awareness of each other's roles. Occupational therapists in Tollbury quoted the term 'them and us' explaining the concept of the two different organisations making up the reablement service, having different agendas (discussed further in section 5.7.4.).

Support workers in Foybrook described using the plan written by the occupational therapist to guide their work with the service user. There was less evidence of face to face contact, communication and feedback between the support workers and the occupational therapists. The manager of the independent organisation in Foybrook, Maisie, described the support workers as working alongside occupational therapists, suggesting a parallel approach of the two organisations.

Support workers in the same case study talked positively about their past experience of greater contact between staff members. They described a time when occupational therapists were present at the first visit to the service user by the independent organisation. During data collection this practice wasn't occurring. Those that experienced it in the past felt that it was helpful as the occupational therapists:

'knew what they were doing, how to go about it, make a telephone call to whoever and get the equipment you needed'

(Flynn, support worker team leader, Foybrook)

This contact reinforced trust between reablement team members. Support workers in Foybrook confirmed their trust in occupational therapists to resolve difficulties, to enable support workers to work on the reablement plan with service users. In contrast the manager, Maisie, highlighted issues with occupational therapists being present on the support workers' first visit to service users asserting that the two

organisations had different agendas. Maisie explained that the organisation had paperwork to complete under their Care Quality Commission (CQC) registration and they wanted to introduce the service user to their company, and the way reablement was undertaken. Maisie asserted that the occupational therapists' goals and plan sent to them following their assessment, was enough for the organisation to use to discuss specific details of the reablement plan with service users.

Maisie further described a difference between the initial pilot of the reablement service undertaken in a small area and the current countywide service. The original pilot reablement service had dedicated occupational therapists with a remit to undertake visits with support workers on their first visit. In the pilot phase the occupational therapists had more face to face contact with support workers, including training support workers. As the service expanded to cover the whole county communication between organisations was considered more difficult as less time was available for training and face to face contact between the different agencies. A recent support worker to the reablement team in Foybrook, when asked how she would explain the role of occupational therapists to service users, said that no one had ever explained the occupational therapist's role to her. Foybrook introduced shadowing between different organisations to develop understanding in each other's roles. Several team leaders in the setting shared a willingness to work more closely and suggested monthly meetings as an option to improve communication between the two organisations.

5.7.3 Feedback on service user progress

Support workers were identified as the members of the team who spend the greatest proportion of time with service users, and therefore could identify change in service users. Support workers provided regular feedback to occupational therapists and this feedback served to review the progress of service users and decide whether additional support or equipment was required. Alongside identifying equipment that may support service users, support workers also provided feedback on use of existing equipment - whether it was beneficial or not beneficial for the service user:

'If a piece of equipment has gone in then they'll say "oh yeah it's working really well for Mrs Bloggs. She's doing brilliantly with it" or "actually no, she's really not getting over it. I'm really worried". In which case then we can go back out and review it at that point'
(Hannah, occupational therapist, Averdale)

Means of communication between support workers and occupational therapists varied in each case study. Some support workers communicated via their reablement team leaders and some contacted occupational therapists directly. In Foybrook, support workers contacted occupational therapists. They asserted, and their supervisors and managers agreed, that they knew the detail of the service user's difficulty so were best placed to explain issues. A senior occupational therapist in Foybrook confirmed this practice and expressed concern about consistency of communication as support workers were more likely to contact occupational therapists that they knew. This was demonstrated during observations. Whilst in the office I observed an occupational therapist receiving a telephone call from a support worker who she knew, who asked her for help with a service user.

Support workers in Foybrook and Averdale highlighted timeliness of response and provision from occupational therapists as key to meeting service users' needs. A delay in response from occupational therapists was highlighted as significantly affecting the ability to reable a service user. One support worker said:

'We're back to square one because we have to go right through the whole process of trying to reable that person'. (Joy, Foybrook)

Each case study employed a significant number of support workers. In Tollbury, support workers attended weekly review meetings to discuss the progress of service users and consider reducing or increasing the number or duration of visits or identify if other support or further referral was required. Due to shift patterns, not all support workers were able to attend each meeting. If the support workers present had not visited the service user for several days, feedback was described as '*patchy*' (Pete, occupational therapist, Tollbury). In Averdale, a team leader from the independent organisation attended the meeting to represent the support

workers. In both areas there were occasions when either the team leader was unable to attend the meeting or the meeting was cancelled due to the independent organisation being short staffed. On these occasions occupational therapists sought feedback in different ways such as visiting the office of the independent organisation or telephoning support workers directly.

Weekly review meetings were not held in Foybrook. The independent organisation were expected to provide regular feedback on service users' progress on their goals. The Local Authority manager, June, asserted that this feedback was important prior to the formal review undertaken before the end of the reablement plan. June shared that they were not currently receiving this feedback. The manager of the support worker organisation, Maisie, when asked about feedback, asserted that they usually provided feedback weekly but this depended on the complexity of the situation. She suggested that they worked in a person centred way and would provide minimal feedback for service users considered 'straightforward' and communicate more if the situation was deemed as complex.

5.7.4 Disagreements between reablement team members

A formal review of reablement support was a process undertaken with all service users in each of the case studies. The result of the review was either ending reablement support, or referring service users to other services to receive further support. Members of the reablement service across the two organisations did not always agree on whether a reablement package should finish. Differences in priorities was suggested as a reason for these disagreements.

Occupational therapists in Tollbury perceived that the focus of the independent organisation was to finish reablement with one service user, so they could start working with a new service user. This perception was based on the context of the organisation's contract that set targets of how many service users the organisation should support. During observations occupational therapy staff received telephone calls from reablement team leaders in the independent organisation to discuss finishing reablement support with some service users. Clare and Gill commented:

'I think the remit of [name of independent organisation] is to get as many of their stats points as they can that is to open as many cases as

they can, reduce them and close them'. (Clare, occupational therapist, Tollbury)

'I feel there is a huge amount of pressure put on me to finish service users or cut calls and actually I don't want to yet. I want to give them time. I sometimes feel the information they are giving me back about service users isn't quite the whole truth. ...today I've gone in the office and two of the support workers have been out to see a service user and one has said "oh yes he's fine he can do that" the other one's looked at me and pulled a face and [said] "well I'm not so sure he wasn't great with me at doing that". And I know that one wants to close it because they want to take on other people and the other one isn't too bothered. So I feel like I'm always having to fight' (Gill, occupational therapist, Tollbury).

Disagreements between the occupational therapists and the independent organisation occurred over the need for ongoing care. Occupational therapists saw their recommendations as considering the 'whole' service user. An occupational therapist, in Averdale, provided the following example of considering fatigue as well as physical ability:

'a lady who I had been working with. I had done a washing and dressing assessment with her. I had identified that she needed ongoing care because she had a heart condition and became really fatigued if she washed on our own. Whereas she could physically do it, she then couldn't do anything for the rest of the day. Whereas the independent organisation felt that that person, because what they had seen was that she was able to do the activity independently, so there was a bit of disagreement over whether she should be referred for an ongoing package of care or not (Barb, Averdale)

5.8 Programme theory 6 - shared purpose and 'buy in' to reablement

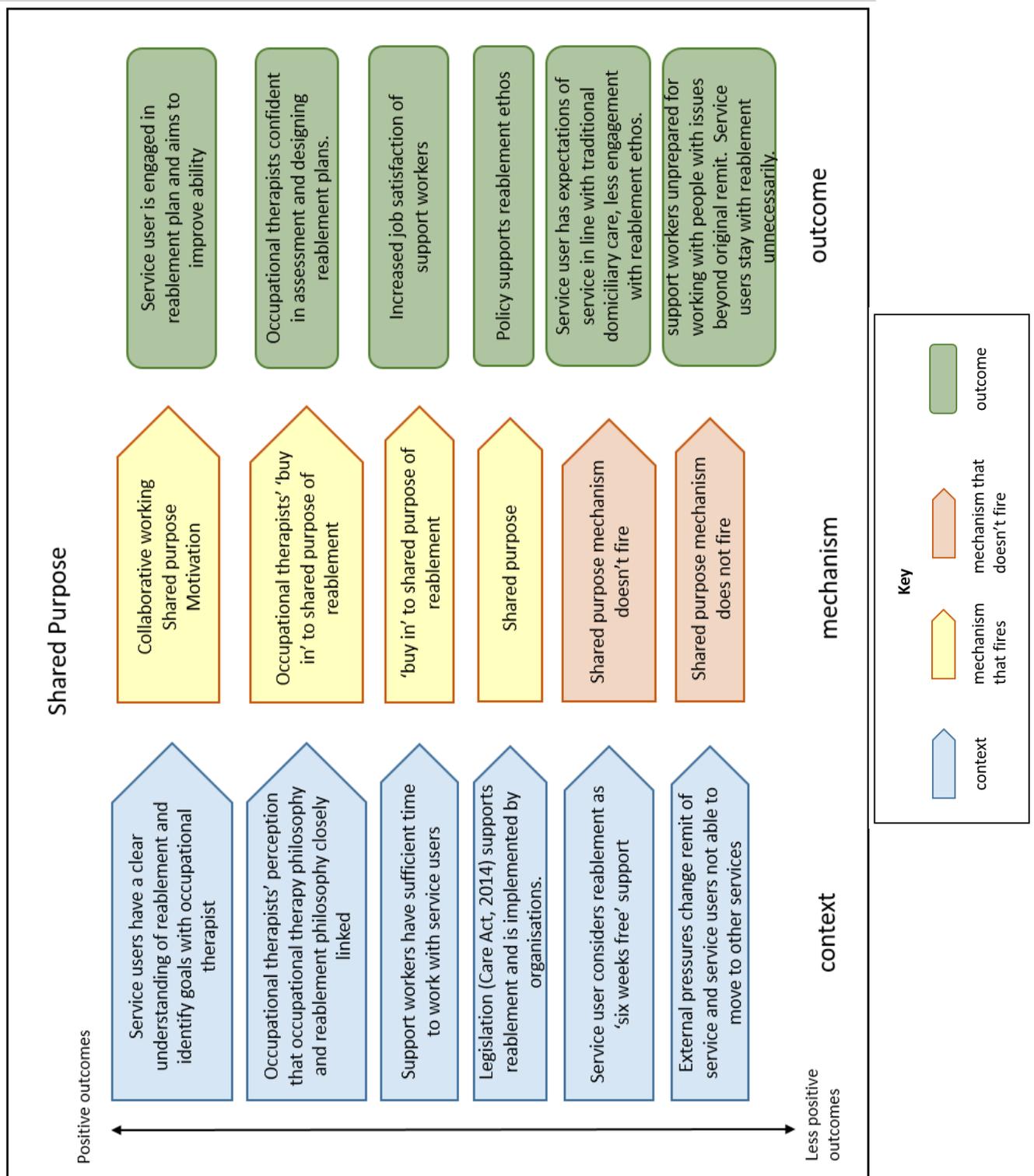
The second new programme theory identified from the case study data focusses on all stakeholders in reablement understanding the purpose of reablement and committing, or 'buying in', to the ethos of reablement, see box 12.

A shared purpose of reablement by service users, occupational therapists, support workers and legislation supports engagement and collaborative working with service users, increased satisfaction by support workers and occupational therapists confident in assessment and the reablement approach.

Box 12 Programme theory six - shared purpose and 'buy in' to reablement

Discussions about the development of reablement services demonstrated that a reablement way of working often involved a change of working practice and ethos for members of staff in the team. Staff commitment to the ethos of reablement was identified as an underlying mechanism leading to positive outcomes. The context mechanism outcome configurations developed from the research data are illustrated in figure 13. Occupational therapists were confident in working with the ethos of reablement as they considered the principles of reablement as closely linked to occupational therapy philosophy. Interventions and contexts that supported shared purpose and 'buy in' for staff were training, availability of time to spend with service users and organisation policies. For reablement to be effective service users also needed to 'buy in' to reablement through additional mechanisms of motivation and collaborative working.

Figure 13 CMO configurations - shared purpose



5.8.1 Occupational therapy philosophy and reablement

All occupational therapists in the study commented that they were committed to the ethos of reablement of supporting people to do more for themselves.

'I went [in]to OT and that was what I was born to do...my ethos in life, it fitted. I'm not a doer for people. I'm a 'let's work alongside someone' (Clare, Tollbury)

When asked about their primary role in reablement one occupational therapist said:

'promoting independence with activities of daily living' (Barb, Averdale)

Occupational therapists and their managers emphasised that reablement and occupational therapy were closely linked:

'I think we really need to buy into reablement. I think OT's time has come with reablement'. (June, manager, Foybrook)

'I just feel like the whole ethos of occupational therapy and reablement just sits so well together. I think we can see people's potential' (Clare, occupational therapist, Tollbury)

'I think that OT is the core profession for reablement... we have those skills to look at the whole picture, and to look at their environment, and to make small changes which make a big difference on their package of care and their ability to manage things independently; because everything in reablement is function and that's our job i'nt it!. I think that we've got a really strong role in reablement'.

(Barb, occupational therapist, Averdale)

It was suggested that reablement provided an opportunity to work on occupational performance, described as function, assess and adapt the environment if required and teach techniques. This was seen as within the domain of occupational therapy and a shift from the traditional approach of social care of providing care at home. Moving to a reablement approach involved all members of the team.

5.8.2 Support workers 'buy in' to reablement

All independent organisations recruited support workers who had previous experience in caring and/or held vocational qualifications in care. For support workers who had prior experience, reablement often involved moving from 'doing for' a person to supporting service users to do more for themselves. Occupational therapists described the need for a transition to supporting people to do more for themselves as some support workers were '*used to doing for people*' (Pete, occupational therapist, Tollbury) Pete also identified providing a continuum of support as some support workers did not support people enough. He explained that some support workers could be '*too forthright and aggressive*' asking people to do things before they were ready.

Occupational therapists promoted the ethos of reablement with support workers in all settings, particularly at the development stage of reablement services. In Tollbury occupational therapists demonstrated equipment, presented scenarios and asked the support workers what they would do in that situation. The occupational therapists then provided feedback to support workers to support their learning. The experience of the occupational therapists was that some support workers found it more difficult to work in a reabling way. Occupational therapist, Gill, described completing a joint visit with a support worker who started to 'do for' the service user. Gill halted the support worker; reiterating her role to step back. Gill perceived that time and pressures of workload, were factors factor impeding working in a reabling way:

'I think they are massively rushed. They have visit after visit after visit so they don't have that time sometimes to give people. So thinking "I just have to get in, get this done and drive over to another one". They just don't get given the time and space to do reablement'

(Gill, occupational therapist, Tollbury).

Another occupational therapist surmised that personality affected the support worker's approach:

'I think because of their nature and their personality they want to care for people. They want to do for people'
(Angela, occupational therapist, Foybrook)

The willingness to care was evidenced during an observation of a visit with occupational therapist Grace, in Foybrook. A support worker from the reablement team arrived during our visit and her first sentence was *'do you want me to do anything for you?'* The service user provided specific instructions about what she would like for her lunch. The support worker prepared the lunch for her and then left the property five minutes after arriving. The support worker had undertaken a traditional care role, doing the task of making lunch for the service user. She did not ask the service user whether she was able to make any of her lunch. The support worker focused on the task of ensuring the service user had some lunch to eat.

Support workers recognised the need to change their practice from the traditional care role.

'My biggest transition from doing core care to reablement was learning to stand back a little bit. Because when you're in care you're very hands on and it's all about doing'. (Suzy, support worker, Averdale)

Support workers described slipping into their old role, focussing on the tasks that needed to be completed. Suzy further described a home visit when she was reminded not to do things for the person, by the occupational therapist. Suzy said: *'but he was sat there eating his breakfast. He was 20 minutes eating a bowl of cereal'*. (Suzy, support worker, Averdale)

The support workers in the first focus group in Averdale confirmed that they were used to working to a tight timescale so were aware of how they were using their time. They described the role in traditional care as *'tick the boxes and run'*. The support workers all appreciated having adequate time to spend with people on reablement and highlighted that supporting people to do more for themselves was very rewarding. Positive job satisfaction from working in a reabling way was also reiterated by a support worker in Foybrook:

'I loved it...you could see a difference. You could see that you were doing something' (John, support worker, Foybrook)

5.8.3 'Buy in' by service users

An understanding of the ethos of reablement by service users was seen as crucial to successful outcomes in reablement. A joint commitment to supporting people to do more for themselves was proposed by Jane (occupational therapist, Averdale) as leading to collaborative working between the service user, their family and the reablement team.

Examples were given of working with service users who did not understand the purpose of reablement. Gill (occupational therapist, Tollbury) shared the comment of a service user who asked what she was *'signing up to'*. A number of support workers in Foybrook expressed the view that occupational therapists and social workers described the service as domiciliary care rather than reablement at the outset. It was suggested that this led to service users expecting support workers to complete tasks for them; rather than support them to do more for themselves. This was particularly evident when a service user had received domiciliary care prior to an admission to hospital. It was commented that the service user expected a similar service from the reablement team.

Occupational therapist, Chloe (Foybrook), in the same reablement service conveyed her perspective that the message of the ethos of reablement was often *'lost in translation'*. She could identify service users for whom she had clearly explained the remit of reablement who later said they did not know they were being discharged with a reablement service. In contrast to this Chloe also shared her experience of working with other service users who did understand the ethos of reablement, and reminded the support workers that they should be encouraging them to do more for themselves.

For other service users occupational therapists explained that they had to manage high expectations of reablement. Hannah, occupational therapist (Averdale) had worked with a service user who described what she wanted as *'the moon on a stick with sparkles on it'*. She said that service users with high expectations can get frustrated when the service can *'only give them the moon'*

5.8.4 'Six weeks free'

Reablement services in all case studies were designed as short term support for up to six weeks, with some flexibility to extend. Unlike standard social care support that is subject to a financial means test, reablement services are free to the service user. Some occupational therapists described the difficulty of the term 'six weeks free'. This term was asserted as raising the expectations of service users and family members. Gill (occupational therapist, Tollbury) recalled attempting to end reablement support as the service user was independent in her daily occupations. Family members did not accept the reablement service stopping their support stating that they were '*promised six weeks free care*'.

During observations with Clare (occupational therapist, Tollbury) we visited a service user and his family who were displeased with the service they received from reablement. The service user had had support from a domiciliary care agency before being admitted to hospital and the family expressed anger that the support workers would not do what the previous support workers did. The service user's daughter relayed that she understood that reablement was '*six weeks free care*'.

For service users who did not initially understand the ethos of reablement, discussing and agreeing goals (also described in section 5.3.3 above) was a method used by occupational therapists to seek information from service users on what they wanted to be able to do.

5.8.5 Service user motivation

When goals were set collaboratively with service users, motivation was triggered and service users engaged with the reablement service. Occupational therapists linked motivation with ownership of goals:

'She was really motivated to be independent so goal setting was really easy with her because she knew exactly what she wanted'

(Zoe, occupational therapist, Averdale)

In contrast, occupational therapists described service users who did not wish to set goals for reablement. In these cases, the mechanism of 'buy in' to reablement did not fire. Service users made comments to occupational therapists such as '*well I never asked for reablement. I just want care*' (Gill, occupational therapist, Tollbury).

Barb (occupational therapist, Averdale) described visiting a service user who felt that because she was a certain age she was entitled to visits several times a day. This reduced motivation to engage in reablement inhibited the writing of goals between the service user and the occupational therapist.

5.8.6 'Buy in' at the organisation level

Having a shared purpose and 'buy in' to reablement was important at the level of the organisations involved in the service. Descriptions of the support worker role given by managers in the independent organisations demonstrated the ethos of reablement. The manager in Foybrook described the support workers role with service users to:

'help them get back their independence if that's what they're working towards' (Maisie, Manager, Foybrook)

The manager of the independent organisation in Averdale felt that her support workers could support service users with different activities if they received more training from the occupational therapists.

5.8.6.1 The impact of legislation

The Care Act 2014 (Department of Health, 2014) is the current main legislation for social care. All managers were aware of this legislation. The manager of Averdale, Emily, cited the focus on prevention in the Care Act 2014 as a foundation for reablement services. June, the manager in Foybrook, discussed the duty to undertake assessments in the Care Act 2014 as a key feature in social care in general. Due to the broad criteria already in place for reablement she asserted that the Care Act 2014 had not significantly affected reablement. The manager in Tollbury, Martin, was interviewed prior to the enactment of the Care Act. He was aware of the forthcoming content of the Act and welcomed the focus on holistic assessments of psychological as well as physical needs. He highlighted a concern regarding the skills of support workers to support a variety of people. He said:

'I've actually had to turn away people who have had acquired brain injuries not because I didn't think it was good work or even that they were eligible for reablement. I had to say to the referrer I actually don't

think the support workers we have on board have the skills to actually understand that you're working with a person's lifestyle here and you're trying to enable that person within that lifestyle to make safe choices and also to learn at the same time where they are, what they're doing and how they are doing it' (Martin, Manager, Tollbury).

5.8.6.2 Who can be supported by reablement?

Each case study differed in their remit for who the reablement service could support. People with palliative care needs were generally not considered suitable for reablement as they are less likely to improve their ability to complete daily occupations. However, two occupational therapists provided examples of working with people with palliative care needs; supporting them to be as independent as possible in the occupations important to them.

A support worker in Foybrook, John, shared that their service had been asked to work with a person who was partially sighted on cooking skills and learning to get to the shops. John explained that he and his fellow support workers hadn't received any training on working with people with visual impairments and did not know what to do. When the support workers asked their organisation for training in this area they were advised that the reablement service was not intended to work with people with visual difficulties so they would not need training on this. As the context of the remit of reablement expanded, training wasn't provided to support this.

5.8.6.3 The integrated health and social care team

In Averdale the reablement service was a joint health and social care team. The remit of the team included preventing hospital admissions of service users experiencing acute health issues such as falls or infections. Reablement was used to support a person in the short term, whilst they recovered from their infection. Both the manager and one of the occupational therapists asserted felt that these cases were not really reablement:

'because as soon as they've got over their water infection they're back to their normal level of function anyway'
(Barb, occupational therapist, Averdale)

The increased emphasis by central government on supporting people at home, rather than in hospital, was cited as a context increasing the workload of the health and social care reablement team. Hannah (occupational therapist, Averdale) described a dissonance between health commissioners, focused on supporting medical recovery through reablement, and social care commissioners concerned with enabling service users to be as independent as possible, to provide a baseline to meeting service users' long term care needs.

The inclusion of the independent organisation was introduced by social care commissioners to increase the capacity of the reablement service. Occupational therapists did not complete the first assessment for service users referred directly to the independent organisation. They only assessed when requested. Not all occupational therapist approved of this approach citing the importance of the occupational therapy role:

'it feels like OT should perhaps have more of an involvement with them because they are reabling in activities of daily living....it's quite hard as a clinician to know that you've done your three years training and experience and you think 'in my clinical opinion this is what should happen' but they've gone in there first and perhaps have a bit more of relationship and that can cause a few crossed wires. So you kind of feel like anyone who hasn't had a care package before, you almost think, needs an OT assessment.' (Zoe, occupational therapist, Averdale)

5.8.7 Right service, right time?

'Right service, right time' refers to whether reablement was the most appropriate service for service users at a particular time. In addition to expressing the importance of occupational therapists assessing service users new to receiving support, participants in all case studies identified service users who they did not think were suitable for reablement. The reasons for this linked to a shared purpose

at a policy and organisation level. The context of pressure to discharge people from hospital was highlighted as a particular concern:

'I think the hospital social workers are so under pressure to get people out of those beds. [Name of reablement service] is just another service that might pick it up'. (Clare, occupational therapist, Tollbury)

'We've unfortunately had to send quite a few referrals back where people just haven't been safe enough, or well enough upon discharge and we've had to send them back in again'.

(Hannah, occupational therapist, Averdale)

Support workers in Foybrook expressed a view that occupational therapists in the reablement team based at the hospital '*bent the rules*' due to pressure to discharge service users from hospital. They described receiving reablement plans from occupational therapists that initially stated that the service user did not have potential to improve with reablement. When the case was declined by the independent organisation the occupational therapist completed another plan with a reablement goal included. The negative outcome of this practice was that support workers disregarded the goals, perceiving them to simply be a means to gain reablement support. A support worker, John (Averdale) shared that as the reablement service were asked to work with service users with little reablement potential, it had, in his words, become a '*dumping ground*'.

In all of the case studies the reduced capacity of mainstream domiciliary care to support people with longer term needs was the main context that prevented service users being supported by services other than reablement. In Tollbury service users who were assessed as not having reablement potential were provided with a reablement service for two weeks to enable the long term service to arrange alternative care. Delays in arranging an alternative service meant that reablement services were supporting service users not intended for their service. This further blocked other service users from utilising the service. The mechanism of 'right person, right time' was not evident. Support workers in Foybrook expressed concern that an outcome of this scenario was that service users built a relationship

with the reablement support workers who visiting them and then had to move to a longer term service and get to know new support workers.

The final observation identified in the mechanism of 'right service, right time' concerned the communication between different health and social care teams working in the same community with the same service user. The following vignette is developed from observation notes of a visit with Grace (occupational therapist, Foybrook) and describes Catherine's contact with different teams.

Catherine had had a stroke. Following a stay in hospital she returned home and was visited by the specialist stroke team. During the visit with Grace, Catherine shared that she was waiting for the health intermediate care team to visit. The reablement team were supporting her with home visits.

Catherine had limited functional ability in one arm. She described regularly undertaking the exercises shown to her to improve the ability in her arm. Catherine's goal was to return to cooking again. She wanted to start with cooking an egg. Grace had assumed that the intermediate care team or the stroke team would support Catherine with cooking. Grace explained that she could support Catherine with this, but would check with colleagues in the other teams if they planned to do so. Grace explained her role in social care and advised that she was the only one who could arrange for a stairlift. Grace had previously established that it was very important to Catherine to be able to go upstairs, as this was where her only toilet was located. Catherine currently only used the stairs when support workers were with her or used a commode that the support workers had to empty for her. Catherine was keen for the stairlift to be installed to enable her to be independent.

Vignette 6 Teams in the community supporting Catherine

In this scenario, Catherine was being supported by three different teams in the community. Each of these teams employed occupational therapists who could support her with cooking. Yet none of them were. Catherine had been in significant pain and it had taken over a month for the stroke team to support her to manage this pain. The short term nature of both intermediate care and reablement teams meant that support was due to come to an end just as Catherine,

her pain now managed, was able to participate in undertaking occupations important to her. This situation serves a reminder of the importance of an individual approach to service users, to provide support when it is likely to be most effective, and the importance of communication between teams to ensure a service is supported with their goals.

5.9 Summary

This chapter has presented the findings from data collected from three case studies through observations, interviews and focus groups. The four programme theories developed from the realist synthesis review of the literature were compared with the data collected.

The first programme theory on the degree to which occupational therapists are utilised in reablement services was less relevant as in each case study occupational therapists were core members of the reablement team. Screening and allocation of work, and referrals from support workers in the reablement service were identified as contexts that support the involvement of occupational therapists with different service users. Senior staff made decisions on which member of the team would best support different service users.

The second programme theory, that the skills and experience of occupational therapists used in a holistic way supports service users to improve their abilities, was upheld. Occupational therapists described working with the 'whole' person using a person centred approach during assessments and goal setting. The mechanism of safety was identified by both occupational therapists and support workers, which had not been identified in the literature. The mechanism of a 'safety override' may lead to less person centred practice as occupational therapists prioritise safety.

The third programme theory was originally focussed on the use of equipment by occupational therapists in reablement teams. Whilst equipment was identified as a key intervention, it was highlighted as an intervention amongst others used by occupational therapists in reablement services. Occupational therapists stressed the importance of analysing difficulties and then deciding on the most appropriate intervention from their toolbox of interventions.

Occupational therapists completed formal training and had regular contact with support workers. This improved the abilities of support workers to be able as recognised from the literature forming programme theory four. The differences in the provision of training over time was highlighted as a context that may not support consistent practice. The data expanded the theory to include the importance of trust between occupational therapists and support workers.

Two new programme theories arose from the data: working as a team; and shared purpose and 'buy in' to reablement at all levels. Communication and trust were identified as mechanisms supporting good practice in reablement. Co-location and building face to face relationships with other reablement team members were contexts that supported working together as a team. Regular feedback about service users being supported by the reablement team was key to effective working, disagreements did occur and some of these were attributed to the different remit between organisations.

The final programme theory was the importance of shared purpose for reablement at all levels of the service. Occupational therapists could see clear links between the ethos of reablement and the philosophy of occupational therapy. Occupational therapists worked with support workers, and for those with experience in traditional care settings, supported them to move from 'doing to' a person to supporting the service user to do more for themselves. Understanding of the remit of reablement by service users varied, with the phrase 'six weeks free' being a barrier to working with service users with a reablement approach. The importance of working on the goals of service users to maximise motivation was also highlighted.

This chapter concluded with a consideration of factors of legislation and organisational policy that affect who is supported by reablement services. This included the contextual difficulties of lack of capacity in other services to move service users onto if they require ongoing support. The following chapter will discuss these findings, comparing themes with relevant literature.

6 Discussion

6.1 Introduction

The aim of this study has been to advance understanding of the role and impact of occupational therapists in reablement services, using a realist approach to identify the factors that influence their practice. The study has focussed on the perspective of occupational therapists, their managers, support workers and the managers of the independent organisations involved in the reablement service. This chapter will address the aim of the study through discussion of the findings presented in the previous chapter in relation to literature concerning reablement, the wider context of social care and working in teams.

The programme theories identified in the realist synthesis alongside the two new programme theories identified during the study have been developed into a conceptual framework of the role of occupational therapists in reablement services (see figure 14). The three time phases of the conceptual framework will be discussed in this chapter: shared purpose, holistic and person centred practice and team approach. The role of occupational therapists in assessment, setting goals and selecting intervention working in a holistic and person centred way will be discussed in the first section. The second section discusses the impact of occupational therapists as members of the reablement team with particular reference to working with support workers.

The following chapter will provide a summary of the research and its conclusions, reflect on the process of using a realist approach and consider recommendations for practice and future research.

6.2 Development of a conceptual framework

As demonstrated in the previous chapter, data collected from each of the case studies supported the four original programme theories to a greater or lesser degree. The research findings from this study expanded the original programme theories and two additional theories were identified. These theories have been formulated into a conceptual framework illustrating the contexts and mechanisms that impact on the role of occupational therapists in the reablement services in this

study (figure 14). Descriptions under the themes represent either contexts, in plain text, **mechanisms** in bold and *outcomes* in italic. The framework illustrates four different layers of reablement.

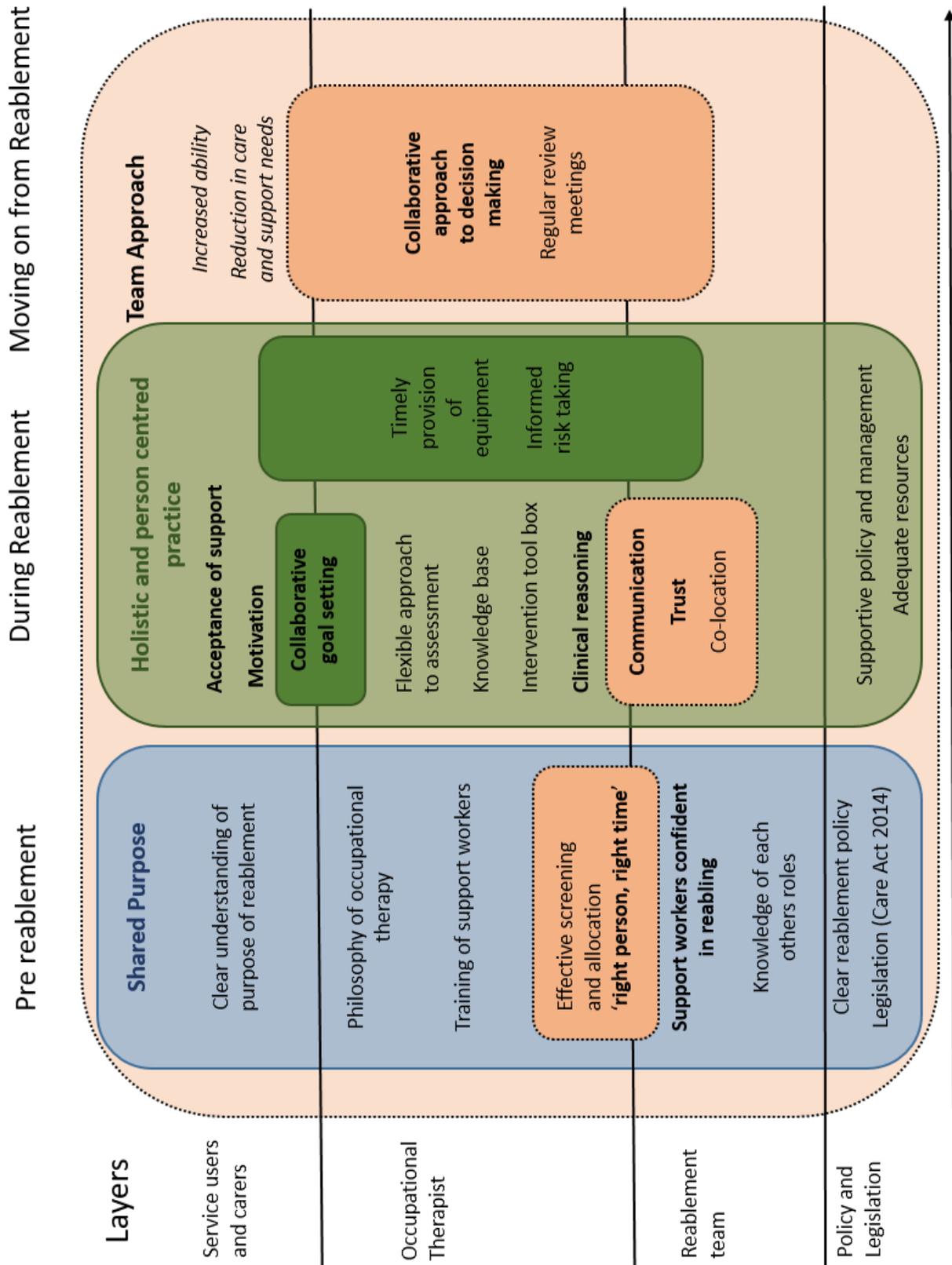
The layers of this conceptual framework incorporate the four contextual layers suggested by Pawson (2006b) as shown in table 7.

Contextual Layer (Pawson, 2006b)	Equivalent Layer in conceptual framework
Wider infra-structural system	Policy and legislation
Institutional setting	Reablement team
Individual capacities	Occupational therapists
Interpersonal relationships	Service users and carers

Table 7 Layers of conceptual framework

The layer titled ‘wider infra-structural system’ represents the influence of politics and community resources underpinning the topic of the research (Pawson, 2006b). For the conceptual framework, I have named this layer policy and legislation. This layer includes legislation, predominantly in this case the Care Act 2014 (Department of Health, 2014) that sets out the duties of Local Authorities, and the policies and guidance that support the practice of reablement. This layer also includes the influence of managerial decisions in practice. Pawson’s layer titled institutional setting, concerns the culture, character and ethos of the institution and is represented by the title of reablement team. This layer in the conceptual framework refers to the reablement service as a whole team with no distinction between the two organisations involved in each service.

Figure 14 Conceptual framework of occupational therapists in reablement services



Pawson's last two layers concern individual capacities of the different people involved in the setting and the interpersonal relationships supporting the intervention (Pawson, 2006b). In my conceptual framework individual capacities and interpersonal relationships are combined into each of the final two layers: occupational therapists, and service users and carers. The layer of occupational therapists was chosen to highlight the contexts and mechanisms affecting the role of occupational therapists, as the topic of research in this study. The additional layer of service users and carers was included as recognition of the importance of the influence of contexts and mechanisms on the person centred approach of reablement.

The framework is separated into three time phases: Pre-reablement, During Reablement and Moving on from Reablement. The Pre-reablement and During Reablement phases are each headed by a theme: shared purpose and holistic and person centred practice respectively. Pre-reablement consists predominantly of contexts deemed important to be in place prior to reablement commencing. Such contexts include having clear policy in place, trained support workers and an effective screening and allocation process. The During Reablement phase includes the main contexts and mechanisms affecting the role of occupational therapists in reablement working with service users and carers, and the wider reablement team. Moving on from Reablement is the phase of reablement with a service user where decisions are made about whether further support is required. This phase includes the outcomes for the service user of increased ability and a reduction in ongoing need for care. Moving on from Reablement is headed by the theme of a team approach. The team approach permeates all time phases and therefore there are orange coloured sections in each time phase demonstrating the influence of a team approach in each phase. The previous chapter presented the findings using programme theories and expanded context mechanism outcome configurations. These configurations included contexts that did not support specific mechanisms to trigger, leading to less positive outcomes. The conceptual framework in this chapter focusses on contexts that support mechanisms to trigger, leading to positive outcomes.

Numerous outcomes for different staff groups, service users and carers were identified in the context mechanism outcome configurations in the findings chapter. Reablement seeks to increase the independence of service users and reduce the need for care and support. This conceptual framework concentrates on the factors that support those outcomes and includes two outcomes for service users: increased ability; and reduction in care and support needs; and one for support workers: support workers trained and confident in reablement.

6.3 Occupational therapy philosophy and the shared purpose of reablement

The Pre reablement phase of the conceptual framework is titled shared purpose, which was important at all layers of the service. At the policy and legislation level the policy of the reablement service affected the role and scope of occupational therapy practice in for example, setting goals and purchasing equipment. At the team level, support workers' training and commitment to reablement supporting trust between occupational therapists and other team members. Service users and carers' understanding of the concept of reablement affected the approach that needed to be taken by occupational therapists. These themes will be discussed further, in section 6.5 that considers the role of occupational therapists as members of the reablement team. This section focusses on the occupational therapists' view of their role within the reablement team.

6.3.1 A clear role for occupational therapists in reablement

Occupational therapists in this study considered occupational therapy as the 'core profession' for reablement stating that they were able to 'see people's potential'. The occupational therapists were committed to the purpose of reablement to support people to be independent and closely aligned this purpose with the focus of occupational therapy to support independence and enable participation in occupations. Chapter one highlighted the use of the word reablement in occupational therapy practice in the 20th Century. The definition of reablement used in this study is:

'Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living' (Care Services Efficiency Delivery, 2007)

The main aims of reablement, using this definition are to support people with the 'skills necessary for daily living'. As described in chapter one this aim mirrors the occupational therapy term occupational engagement, supporting people to engage in the occupations important to them.

Occupational therapists cited their professional education and their ability to consider the capabilities and constraints of the person, the analysis of the task and an assessment of the environment as key features of reablement. These elements of assessment and analysis were supported by clinical reasoning skills that enabled occupational therapists in this study to make decisions concerning different approaches to assessment and what intervention to suggest from their toolbox of interventions.

The occupational therapists in this study were able to describe their role in detail during interview. Their description included the stages of assessment, goal setting and choosing intervention. One occupational therapist highlighted their 'skills to look at the whole picture'. This understanding and commitment to reablement matches the responses of occupational therapists more broadly during conferences and surveys (Nosowska, 2010; Riley, Vincent and Whitcombe, 2008). The Social Care Institute for Excellence and the Royal College of Occupational Therapists have also asserted the importance of the role of occupational therapists in reablement services (Skelton, 2013; Social Care Institute For Excellence, 2011b).

The role of occupational therapists in reablement was also understood and recognised by other members of the wider team in each case study. Senior staff involved in allocation of service users to members of the team recognised when the skills and experience of occupational therapists could be utilised to complete the first assessment, for example when a piece of equipment might support the service user to be more independent. Similarly the managers of the independent agencies requested support from occupational therapists, for example asking for an assessment of a service user's abilities in the kitchen to establish what the service

user was able to achieve. This recognition of the role of occupational therapists is in contrast to previous studies where occupational therapists have perceived a lack of understanding of occupational therapy by others (London-Willis, Couldrick and Lovelock, 2012) or when occupational therapists themselves have struggled to define their role (Finlay, 2001).

Low recognition of the role of occupational therapists has been linked to the paucity of occupational therapists in management positions. Occupational therapists in London-Willis, Couldrick and Lovelock (2012) study of personalisation asserted that poor representation of occupational therapy at a management level led to limited understanding of the role of occupational therapists. In this study the managers of the reablement service in each case study was an occupational therapist and each of the services had been set up by an occupational therapist. This representation at a strategic level, recommended in London-Willis et al (2012) study, supports the concept that occupational therapists in managerial positions promote the role of occupational therapy and increase recognition of the occupational therapists' role in practice.

6.4 Holistic and person centred practice

The second phase of the conceptual framework is titled holistic and person centred practice. This phase represents the factors influencing reablement at all layers of the service: the service user and carer, the occupational therapist, the team and the policy and legislation. Occupational therapists in this study described their practice as both holistic and person centred. Whilst not all occupational therapists used the term holistic they referred to taking into account the 'whole person' and considering the different aspects of someone's life. The therapists' comments resonate to some degree with the description of holism of Sakellariou and Pollard (2009) who relate holistic practice to a process of developing skills in analysis, or reasoning, rather than gaining knowledge of set competences. They describe holism as '*knowing how to know that which matters*' (Sakellariou and Pollard, 2009, p.51).

Holistic and person centred practice were identified as mechanisms in this study, supported by the mechanisms of communication, rapport, trust and using a

collaborative approach. These mechanisms were triggered by the contexts of the knowledge and skills of occupational therapists and occupational therapists using a number of approaches when working with service users. Use of a knowledge base was identified as a context that supported decision making, or clinical reasoning. Knowledge gained through professional education and experience was viewed as essential to practice in reablement. This knowledge included approaches to assessing service users, occupations and adapting the environment; knowledge of disabilities and the law; and skills such as moving and handling and provision of equipment. Professional education has been described by other occupational therapists as a 'firm foundation' of knowledge (Doumanov and Rugg, 2003). Occupational therapists in other studies of reablement services have highlighted their breadth of knowledge of medical conditions as useful in supporting service users to take risks (Calderdale Council and Yorkshire and Humber Joint Improvement Partnership, 2010). In contrast, in this study knowledge and skills also highlighted risk. When risk was identified occupational therapists felt responsible for the safety of the service user and sought to write reablement goals focussed on reducing risk. This is discussed further below, section 6.4.3.3

Finlay (2001) identified four assumptions of holistic practice in health care, represented in box 13. These assumptions differ from the definition of Sakellariou and Pollard (2009) who focus on skills in analysis to present theoretical underpinnings in the first three assumptions, and action in the fourth.

1. Humans should be viewed as unique, integrated beings where mind, body and spirit are intertwined.
2. States of health and illness arise out of an interaction of physical, psychological, social and environmental factors.
3. People have a self-healing capacity when they are able to take responsibility and determine what is needed for their own health.
4. Health care should aim to create lifestyles conducive to personal fulfilment, health maintenance, and integration with the environment

Box 13 Assumptions of holistic practice in health care (Finlay, 2001, p.269)

Finlay observed four occupational therapists in practice and interviewed a further nine occupational therapists. The interviews were unstructured and following data analysis three themes emerged related to holistic practice: the celebration (valuing holism); the search (identifying the meaning of holism in practice) and the struggle (tensions of applying holism in practice) (Finlay, 2001).

The theme of 'the celebration' identifies how occupational therapists were committed to holistic practice with specific reference to the second and fourth assumptions (box 13) of looking at different contexts of a person and considering lifestyles. The participants in Finlay's study mirrored comments of occupational therapists in this study that holistic practice was a key feature of occupational therapy, considering the 'whole' person more than other colleagues. Finlay's theme of 'the search' highlighted the difference in meaning of holism for different occupational therapists. Listening, person centred practice and choice were considered as key features of being holistic. These aspects featured in occupational therapy practice in this study.

Occupational therapists in this study described themselves as person centred and person centred practice was observed during home visits as occupational therapists listened to service users and their carers and sought to set goals that were important to the service user. Person centred practice, as described in chapter one, is described as a partnership between the occupational therapist and the service user (Sumsion, 2000). The service user's needs, values and goals are at the centre of assessment and intervention. (Parker, 2012) held a focus group with 25 occupational therapists on the nature of person centred practice (named client centred practice in her study). Her findings indicated that occupational therapists understood person centred practice and could express practical approaches to being person centred such as having good communication, but that therapists did not recognise the importance of partnership. In essence they understood the theory of person centred practice yet struggled to achieve a partnership relationship with the service user when the goals of the service user and those of the occupational therapist were different.

In this study the occupational therapists did not use the term partnership with service users; they described using a collaborative approach. Using different

approaches to assessment, including family members and completing an assessment over time were all identified as contexts that supported the person centred mechanisms of rapport, trust and a collaborative approach and led to service users engaging with reablement focussed on their goals. This description of a collaborative approach leading to a focus on service users' goals mirrors Parker's (2012) description of partnership as mutual decision making respecting the individuality of the service user. The similarities in the nature of the phrases suggests that using a collaborative approach was a phrase in the language of the occupational therapists rather than a rejection of a partnership between themselves and service users.

The final theme in Finlay's (2001) study, 'the struggle', reiterates some of the issues found within the present study. The occupational therapists in Finlay's study expressed the difficulties in being holistic and person centred working within the contexts of financial constraints and a high workload. It was perceived that management did not support a holistic way of working seeking only to fit people into the service they provided. Time to complete assessments was limited and one participant described having to take an assembly line approach providing standard advice, to enable him to keep his job. In the present study this was demonstrated both in the scope of the service and in the provision of equipment (see also section 6.4.5.1 below). Occupational therapists were limited in their ability to be holistic when the reablement service focussed on participation in occupations within the home rather than goals of engagement in occupations in the community. This affected working in a person centred way, focusing on the goals of the service user. If, for example, a service user identified that it was important for them to regain their confidence in visiting the local leisure centre the reablement service was not able to work in a person centred way and support the service user to achieve that goal.

The nature of holistic and person centred practice will be further integrated into the following discussion of the different aspects to the reablement role: assessment, goal setting and intervention.

6.4.1 Therapeutic use of self

In this study establishing rapport was identified as an important mechanism in working with service users and this was observed during home visits. Occupational therapists recognised the importance of working on service user's goals and that developing a relationship of rapport and trust encouraged service users to share their goals with them. This is a positive finding, as a previous study of interactions between reablement team members and service users identified some staff taking a task orientated approach during assessments, leading conversations on a particular topic rather than actively listening to the service user, establishing rapport and focussing on the goals of the service user (Moe, Ingstad and Brataas, 2017).

Identifying the need to establish rapport is akin to one of core processes of occupational therapy the therapeutic use of self (Creek, 2003). Therapeutic use of self has been defined as:

'the intentional, planned use of personal behaviours, insight, perception, judgement, skills and knowledge to optimize the working alliance with clients and enable change' (Polatajko, Davis and McEwen, 2015 ,p.86)

The therapeutic use of self is concerned with building an alliance with service users to support them to engage in the occupations that have meaning for them. Solman and Clouston (2016) assert that both undergraduate and postgraduate education should include study of the therapeutic use of self to ensure it is mastered in practice. They suggest the Intentional Relationship Model (Taylor, 2008) as a framework for studying therapeutic use of self. The IRM presents six therapeutic modes and asserts that occupational therapists' will have a preference for one mode in line with their personality. In this study five of the six therapeutic modes of the model: collaborating, empathising, encouraging, instructing and problem solving (the sixth being advocating) were observed during observational visits with occupational therapists. Occupational therapists did not cite the IRM as a model they were familiar with, neither were occupational therapists asked about education on therapeutic use of self. Observation of collaborating and empathising were observed particularly during assessments of service users. Encouraging, instructing and problem solving were observed during the stage of goal setting and

deciding on intervention. Rather than being linked to education on therapeutic use of self, the modes observed may have developed through experience. Occupational therapists highlighted the role of their experience in developing a 'knowledge bank' that provided a foundation for working with service users and links to their clinical reasoning skills, section 6.4.4.1 below.

In order to build a therapeutic alliance with service users, occupational therapists should consider how their personality affects their approach, and how to manage the presentation of their personal and their public selves.

6.4.2 Presentation of therapeutic self

During observations of home visits occupational therapists in this study demonstrated a professional approach. The way they 'presented' themselves when working with service users can be allied to Goffman's metaphor of the stage. In his seminal text on the performative aspects of private and public identity, Goffman (1959) asserts that in social situations people perform in what he describes as the front region, or front stage. In this region a person embodies acknowledged (but unwritten) standards of politeness and decorum, engages in conversation with the 'audience'. The props in the front stage are the context, the environment in which the person is performing. Occupational therapists were observed to be professional during assessments. They 'performed' as occupational therapists. They held props such as reablement paperwork and notepads to take notes; and tape measures to measure for equipment or adaptations. The context of the front stage was the person's home or hospital bed area. Occupational therapists demonstrated their therapeutic use of self, seeking a working alliance with service users to enable change.

Goffman (1959) also describes the back region, or back stage. This is the unseen area where the performer can relax and step out of character. An example of this is the home visit of occupational therapist Gill to Yvonne described in the previous chapter (section 5.3.3.4). There was a distinctive odour of urine during the visit that Gill did not discuss with the service user. She focussed on the goals of the service user. Once in the car, Gill discussed the strength of the smell and her opinion that Yvonne could not be managing her personal care based on the smell

in her house. During the visit Gill had engaged in therapeutic use (and presentation) of self, perceiving that it was not the right time to discuss the situation. She explained that she made the decision to visit again to discuss the issue. The car can be considered as the occupational therapist's back stage in this instance.

The offices in which the occupational therapists were based were also a front region, or front stage, in the sense that it was their workplace. The office could also be considered as a backstage to working with service users. It was in the office that occupational therapists discussed their service users more informally, seeking advice from others and also reflecting on visits through informal discussion. This informal practice supported newer staff to learn from more experienced occupational therapists.

6.4.3 Assessment

The contribution of occupational therapists in this study was their focus on three essential aspects. These aspects are: the person; the occupation they wished to complete; and the environment supporting engagement in the occupation. These three aspects appear in a number of theoretical models of practice in occupational therapy including the Model of Human Occupation (Kielhofner, 2002), the Canadian Model of Occupational Performance and Engagement (Sumsion, 1999) and the Person Occupation Environment Participation Model (Christiansen, Baum and Bass, 2015) described in chapter one.

The key feature of the occupational therapists' assessments was the focus on occupation, establishing what occupations were important to the service user. Paperwork used recorded the abilities and constraints of the service user, details of the service user's occupations and their physical and social environment. Occupational therapists utilised various approaches to assessment including conversation, observation and physical assessment. Service users were not considered in isolation and families were seen as an important factor during assessments. Using different approaches to assessment again demonstrating the therapeutic use of self.

Occupational therapists sought an approach that would support their ability to engage with the service user, to undertake a person centred assessment. Engaging in person centred assessment was seen as key to identifying the issues that were a priority for the service user in order to problem solve in a collaborative way, using the knowledge and experience of the occupational therapist.

6.4.3.1 Standardised Assessments

All of the case studies had trialled, or were using, standardised assessments. The occupational therapists sought to establish a baseline of the service user at the beginning of the process to demonstrate change in the ability of the service user following intervention. Standardised assessments are a means of demonstrating effectiveness of the service that have been utilised in other reablement services (Nørskov Bødker, 2018; Tuntland, Aaslund, Espehaug *et al.*, 2015). One case study had trialled the Canadian Occupational Performance Measure (Sumsion, 1999) that focusses on service users' goals. The service user rates how well they perceive they are performing an occupation and how satisfied they are with their performance, before and after intervention. The intention being that the ratings provide a record of the impact of the service. No difficulties were identified with service users understanding the scoring system of the Canadian Occupational Performance Measure, as has been found in another study (Nørskov Bødker, 2018), however, occupational therapists were unable to implement the assessment due to constraints of the paperwork of their organisation. Occupational therapists were required to complete the assessment document designed by the organisation that collected information to enable planning of support. The Canadian Occupational Performance Measure is purchased as a paper assessment or a web based application. It is not known whether the financial cost was a barrier to use of the measure.

The case study that utilised the standardised assessment Morrision Occupational Therapy Outcome Measure (MOTOM) (James and Corr, 2004) used it to illustrate improvement for the two contextual layers of the service model: the service user and the reablement team as a service. The assessment was used to demonstrate to service users the progress they had made. The second use of the assessment information was for the commissioners of the service. Whilst the service was not

asked specifically for this information, it was gathered as evidence of the effectiveness of the service. In addition to these two beneficiaries of outcome data this study identified a benefit for a third group of staff: the support workers. Support workers were involved in determining the ratings via the MOTOM throughout the period of reablement. In this way they were involved in the process, seeing small improvements in the ability of the service user. This process provided positive feedback for support workers, which is important for the retention of staff. Feedback is advocated by Bell (2001) who highlights the importance of feedback and supervision for support workers who work primarily on their own. Shared decision making on ratings on assessment tools demonstrates a team approach between occupational therapists and support workers that is discussed below, section 6.5.3.3

6.4.3.2 Moving and handling assessments

Occupational therapists in the all case studies completed the first assessment with service users to agree goals and plan support from the reablement team. Occupational therapists also had a specific remit concerning moving and handling. In all case studies support workers and their managers sought the advice and guidance of occupational therapists concerning how to work with service users for the safety of the service user and the support workers. In two case studies the occupational therapists had a specific remit to assess moving and handling needs with an aim of reducing support from two carers per visit to one carer by advising on different techniques or providing additional or alternative equipment. The inclusion of the moving and handling assessment role may be linked to the context of the situation. In all case studies the manager of the service was also an occupational therapist who may have been aware of evidence from other Local Authorities of the effectiveness of occupational therapists in enabling moving and handling support to be completed by one person leading to a reduction in ongoing care needs and a financial saving (Charlton, Bone and Billing, 2015; Danks and Toland, 2017).

6.4.3.3 Occupational therapists' values and the safety override

Considerations of safety was evident from occupational therapists as well as managers. For occupational therapists, safety was linked to their own values and beliefs pertaining to keeping people safe. Promoting safety at home has been advocated as an important aspect of occupational therapy practice alongside improved independence and quality of life (Horowitz, Nochajski and Schweitzer, 2013). The authors relay evidence of the environment leading to accidents and falls, with a resultant decline in health, and provide examples of how equipment and adaptations can increase safety and independence.

There is evidence of occupational therapists considering safety within their practice in other services; particularly safety of service users in their home environment. The Home Safety Self-Assessment Tool and the Cougar Home Safety Assessment (Fisher, Baker, Koval *et al.*, 2007) are just two examples of assessments developed for occupational therapists. The Cougar Home Safety Assessment consists of 52 criteria to assess safety in areas such as fire and electrical safety, and readiness for an emergency. In a study of the use of the Cougar Home Safety Assessment only five of the 13 occupational therapists who took part said that they would use the assessment. The occupational therapists' stressed the importance of assessing the ability of the person as well as the environment (Fisher, Baker, Koval *et al.*, 2007 2007). This response from the occupational therapists was evident in this study. Occupational therapists focussed on assessment of the service user engaging in occupations in their own environment rather than assessing the environment independently. For example one occupational therapist was observed assessing a service user undertaking an activity such as getting up from a chair and recognising a risk in completing that activity, rather than assessing the environment for risks.

In this study occupational therapists commented that they felt responsible for a service user's safety in their home. Writing goals related to safety was an example of imposing an occupational therapist's goals rather than working on the goals of the service user that has been identified in other studies. Russell, Fitzgerald, Williamson *et al.* (2002) identified a 'safety clause' in their discussion of the adoption of the term independence in occupational therapy literature from its earliest inception. The authors completed 'critical incident' ethnographic

interviews with 12 occupational therapists in Australia who worked both in hospital and community settings, to ascertain their understanding and experience of independence in their work. Occupational therapists in the study perceived independence both as physical self-reliance, people being able to do things by themselves; and as having autonomy and choice, which has also been seen in other studies (Taylor, 2001). With respect to autonomy Russell, Fitzgerald, Williamson *et al.* (2002) identified conflict between person centred practice and working on the goals of the service user, and the occupational therapists' view of the situation. The authors title this '*the safety clause*'. Safety issues were asserted as having the ability to override the service user's wishes. Occupational therapists provided vignettes of determining a service user as unsafe in completing activities. The vignettes demonstrated conflict between the service user's right to make their own choices and what the occupational therapists believed was their professional responsibility in terms of ensuring the service user was safe. In this way they held the professional power in the situation. Occupational therapists spoke of attempting to persuade service users to accept the support they thought was best for the service user and referred to personal and professional consequences if, for example, someone injured themselves.

Russell, Fitzgerald, Williamson *et al.* (2002) conclude that occupational therapists need to consider what true person centred practice is. There is a contextual issue to consider as their research was undertaken in Australia. In the UK service users clearly have the right to make what occupational therapists may consider unwise decisions if they have the mental capacity to do so, according to the Mental Capacity Act (Department of Health, 2005). A recent publication by the Royal College of Occupational Therapists (2018) on risk and choice highlights the role of occupational therapists to eliminate, reduce or control risks where possible as part of the overall objective to support a person to achieve their goals. The role of occupational therapists should be to discuss risks with service users when agreeing goals to ensure service users are making an informed choice when completing occupations that occupational therapists may consider 'risky'. This epitomises a person centred approach. That being said, the findings of this study also identified the mechanism of safety override related to the second mechanism of trust between

occupational therapists and support workers and their managers. Support worker managers sought assistance from occupational therapists to assess situations to enable their support workers to engage in safe practice. These findings concur with other reablement studies where support workers sought input from occupational therapists to assess for example the service user's level of risk using a kettle in the kitchen (Kent, Payne, Stewart *et al.*, 2000). These assessments of risk would relate to the goals that have been agreed, with support workers seeking advice to work with the service user to be more independent.

6.4.4 Goals for reablement

Being person centred means considering the service user as the expert in their own experience. The role of the occupational therapist is to agree goals with the service user based on the service user's priorities. All the occupational therapists in this study worked with service users living in their own homes, with a variety of physical and/or cognitive difficulties, interests, values and roles. As such, one might expect broadness and variety in goals based on the multitude of occupations that may be important to the service user. A survey on participation in occupation completed by 155 older people receiving support at home identified moving around the home, personal care, dressing, management money, socialising and leisure facilities as the most important occupations in their life (Vik and Eide, 2014). The occupational therapy definition of occupation categorises occupations as self-care, productivity or leisure (Creek, 2010). In this study in all the case studies occupational therapists described their role as '*doing the basics*' with people. This largely consisted of working on person care tasks, kitchen skills and moving around the home. This finding is congruent with other reablement studies that found that goals for reablement were largely confined to occupations within the service users' homes (Glendinning, Jones, Baxter *et al.*, 2010; Whitehead, Walker, Parry *et al.*, 2016). Interestingly preparing meals were of lower importance to older people in Vik and Eide's (2014) study that socialising and leisure activities.

Occupational therapists in this study asserted a desire to work with people on a broader basis, supporting people to walk to the shops, compared to having food delivered; or supporting people in the short term to increase their confidence in attending groups or events in the community. This finding is positive as a previous

study of assessment in social care found that practitioners focussed assessments on physical health, communication, person and domestic assistance, basing their discussion topics on assumptions made from referral information and perceived intrusiveness and sensitivity of topics for service users (Foster, Harris, Jackson *et al.*, 2006)

In this study occupational therapists discussed leisure occupations. Time was given as a reason for not supporting people with occupations of leisure or productivity outside of the home. The remit of the service was also identified as a reason for concentrating on self-care and productivity (for example, making a meal) occupations within the home. This impact of policy at the contextual layer bears similarities to Finlay's (2001) discussion of the 'struggle' of occupational therapists to be holistic, previously described. The occupational therapists in Finlay's study describe having to fit people into existing services rather than be able to meet needs. Similarly lack of resources has been identified as a reason for not supporting needs outside of person care (Foster, Harris, Jackson *et al.*, 2006). Older people receiving support have also asserted less satisfaction in engagement in leisure activities and community activities (65% of respondents) compared to 90% of participants being satisfied with engagement in personal care occupations (Vik and Eide, 2014). This reiterates the challenge for occupational therapists in reablement to engage in person centred practice focusing on goals important to the service user.

Occupational therapists in this study had some flexibility in the reablement provision provided, such as when and how support would be provided, within the limitations of the remit of the service that focussed on 'the basics'. Despite not always being able to provide direct support occupational therapists often provided advice and recommendations for service users to be able help themselves, such as providing information on charities and advice on gardening from a wheelchair. The Care Act 2014 places a duty on Local Authorities to provide advice and information to promote wellbeing. Occupational therapists in this study highlighted the need to have an awareness of local information to advise service users when required.

A study of reablement by Aspinal, Glasby, Rostgaard *et al.* (2016) discusses the importance of reablement teams working with service users to reconnect with

leisure and social activities outside of the home as well as working with people inside the home. They argue that older people, who represent a considerable percentage of service users in reablement services, consider this within their human rights for services to be inclusive and not ageist. Focusing on the goals of the service user has been asserted as a motivating factor for service users. An evaluation of a reablement service based on the goals of each service user demonstrated a significant increase in self-reported ability to engage in occupations following engagement in the reablement programme (Winkel, Landberg and Ejlersen Waehrens, 2015).

Documentation in each of the case studies in this study stated the role of reablement to support independence, independence means different things to each person. Reablement has different titles and definitions across the globe and reablement interventions have not been well described in published studies of reablement (Pettersson and Iwarsson, 2017). I concur with the authors who assert the requirement for a 'more coherent and consensual understanding of what reablement entails' (Aspinal, Glasby, Rostgaard *et al.*, 2016, pg 576). This is important for the policy layer of the conceptual framework.

Reablement services are registered with the Care Quality Commission who inspect services using questions from their Key Lines of Enquiry (Care Quality Commission, 2018). The Key Line of Enquiry titled Person Centred Care, points RL3 and RL4, refers to the service supporting people to follow their interests and access the community, education and work as appropriate. It also refers to encouraging and supporting people to develop and maintain relationships with others. The caveat to these points is the phrase 'where the service is responsible'. This illustrates the need for policy makers in the organisation to confirm the remit of the reablement service. This is a challenge for Local Authorities working within finite resources. Aspinal, Glasby, Rostgaard *et al.* (2016) further argue that a reablement service with a goal of service users requiring less support may lead to increased experiences of isolation and loneliness.

A study of perceptions of loneliness in service users by practitioners working in an intermediate care team in the community highlighted the impact of loneliness on service users' physical and mental health and reluctance to leave the service (Chana,

Marshall and Harley, 2016). Practitioners differed in opinion as to whether they had a role in addressing loneliness directly or referring to another service. Practitioners lacked information on services to refer people to and identified that some service users did not want to engage with others inside or outside of their home to combat loneliness. Loneliness was described as a low priority for the intermediate care team with practitioners citing conflict between holistic practice and the medical model approach of the team.

Social prescribing is an increasing approach of primary care professionals (GPs and nurses) to refer people to voluntary and community sector organisations, often through a navigator, to address the wider determinants of health (Kings Fund, 2017). Social prescribing has been advocated as a person centred approach (Ogden, 2018). Evidence of the effectiveness of social prescribing has demonstrated reduction in admissions to hospital and significantly improvement in measurements of public health, anxiety, social isolation and wellbeing (Dayson, Bashir and Pearson, 2013; Kimberlee, 2016; Polley, Bertolli, Kimberlee *et al.*, 2017). Qualitative studies have identified a perception by health professionals and service users that wellbeing improved and less support from health services was required (Kilgarriff-Foster and O'Cathain, 2015). Occupational therapists have started to engage in social prescribing to support the occupational engagement of service users and promote health and wellbeing (Thew, Bell and Flanagan, 2017).

Person centred reablement services supporting service users to meet their goals could enable occupational engagement of service users in social and leisure pursuits that may have a positive impact on loneliness. Whilst occupational therapists did not identify issues of loneliness in the service users they worked with, service users may not have shared concerns regarding loneliness with their occupational therapist. It was beyond the scope of this research to include service users as interview participants in this study. Interviews with a small number of service users who participated in reablement in Norway expressed the importance of visits from friends and family and going out themselves to visit people, which may be considered as activities to combat loneliness (Hjelle, Tuntland, Førland *et al.*, 2017). The topic of loneliness warrants further investigation within reablement services.

An interesting autoethnography identified workload pressures as limiting the ability of allied health professionals' achievement of person centred practice (Bright, Boland, Rutherford *et al.*, 2012). The demands of the service led to a reductionist approach, focusing on deficits, limiting decision making and goal setting with service users. Mindful listening was identified as key to understanding what is meaningful to service users as a fundamental feature of person centred practice (Bright, Boland, Rutherford *et al.*, 2012). This mindful listening did not occur naturally, it required discipline. Similarly the occupational therapists in this study identified that setting goals with service users that were focussed on the priorities of the service user was something that had developed for them over time. This could relate to their growing skills in clinical reasoning.

6.4.4.1 Clinical reasoning in analysis of situations and decisions for intervention

Occupational therapists in this study described how their ability to focus on the goals of service users had developed over time. Occupational therapists with less experience working in reablement described identifying the difficulties that service users had and suggesting intervention to the service user. This can be described as taking a procedural reasoning approach.

Studies of clinical reasoning have proposed that occupational therapists reason in multiple ways. A seminal ethnographic study of clinical reasoning by Mattingly and Fleming (1994) identified three tracks of reasoning: procedural; interactive and conditional. Previous studies have confirmed the use of these tracks of clinical reasoning by occupational therapists in inpatient and community settings (Fleming, 1991; Mitchell and Unsworth, 2005; Schell and Cervero, 1993; Unsworth, 2001; Unsworth, 2004). In the first track, procedural reasoning, occupational therapists focus on defining the service user's physical issue and use that information to select appropriate treatment and set goals. During interactive reasoning, occupational therapists view service users as individuals with their own perceptions of their situation. The third track, conditional reasoning, involves occupational therapists considering not just the physical condition of the person, but the meaning of the illness for the service user and their family within social and physical contexts. Conditional reasoning is considered the most complex form of

reasoning defined by a multidimensional thinking process, featuring a shared picture of the service user in the future. This level of reasoning in reablement fits with the nature of holistic and person centred practice and enables occupational therapists to focus on the priorities and goals of the service user.

Occupational therapists in this study asserted that their training and experience supported their role in reablement. These factors have been described as the content aspect of clinical reasoning that involves external factors pertaining to the service user themselves, the environment and the task, and internal factors of the habits, knowledge and experiences of occupational therapists (Carrier, Levasseur, Bédard *et al.*, 2012). Past experience and knowledge has also been described as a 'mental cabinet' that therapists access to identify similarities between the current issues and past experiences (Gibson, Velde, Hoff *et al.*, 2000). Habits, knowledge and experiences alongside occupational therapists' beliefs, values, theoretical foundations and training, have been described as a 'filter' through which occupational therapists engage in clinical reasoning (Benamy, 1996).

Occupational therapists' in this study described the importance of knowledge and experience or their 'mental cabinet' alongside their 'filter' of beliefs, values and training to support them in their role. Occupational therapists described their past roles in hospital and community settings as a foundation of experience that provided knowledge of different conditions and intervention techniques and supported decision making in reablement. The occupational therapists demonstrating a procedural reasoning approach had less experience in reablement that has been demonstrated in other studies comparing the reasoning of occupational therapists with less than two years' experience with experts occupational therapists with over four years' experience (Unsworth, 2001). In Unsworth's (2001) study experts demonstrated a flow of ideas both during therapy sessions and when describing reasoning; novices used more procedural reasoning. Experts demonstrated an ability to not just consider a service user in light of previous experience, but also anticipate issues and change the plan of therapy if required.

As clinical reasoning was identified as a mechanism that supported decision making for occupational therapists it is important to develop the clinical reasoning

skills of new occupational therapists to the reablement service. Generic profiles and protocols have been trialled in other services to develop clinical reasoning skills (Carrier, Levasseur, Bédard *et al.*, 2012; Kuipers and Grice, 2009; Stark, Somerville, Keglovits *et al.*, 2015). However, these were developed for specific services such as upper limb hypertonia. The development of a generic profile or protocol in reablement services would be more complex in light of the heterogeneous nature of the service users, their needs and goals. The role of occupational therapists in reablement services is not a set programme working with service users with similar medical conditions or disabilities, experiences or environment. Nevertheless it is important that occupational therapists base their intervention on the best evidence available. Occupational therapists in this study were observed in the office setting discussing service users with colleagues and reflecting on their visits. Reflection has been identified as essential to developing a deeper understanding of a situation and in increasing an awareness of, and cultivating, clinical reasoning skills (Creek and Lawson-Porter, 2007; Gibson, Velde, Hoff *et al.*, 2000; Unsworth, 2001). Bannigan and Moores (2009) assert the importance of the link between reflective practice and evidence based practice and present a Model of Professional Thinking. The model integrates stages of reflective practice with a critical analysis of the therapist's knowledge. The model encourages seeking alternative knowledge and appraising it before considering how they may practice differently in future. The Model of Professional Thinking is a structured approach to supporting the development of clinical reasoning that may be particularly useful for less experienced occupational therapists working in a reablement team with service users presenting a variety of different goals and challenges.

6.4.5 Toolbox of occupational therapy interventions

In this study, the assessment and analysis of the person, the occupation and the environment, supported occupational therapists to use their clinical reasoning skills to decide on intervention using a toolbox of approaches to meet the goals of the person. Ensuring reablement intervention is focused on the goals of the service user has been recognised by professionals elsewhere (Birkeland, Tuntland, Førland *et al.*, 2017; Hjelle, Skutle, Førland *et al.*, 2016). The occupational therapy toolbox of interventions in this study included providing advice, demonstrating techniques

(such as dressing techniques and getting up from a chair), re-establishing routines and provision of equipment to accommodate a difficulty. These interventions have been identified as within the domain of occupational therapy in reablement settings in other studies and papers (Lewin, Calver, McCormack *et al.*, 2008; Silver Chain, 2007; Social Care Institute For Excellence, 2011a). Occupational therapists also provided environmental adaptations, one of the core skills of occupational therapists (Creek, 2003). The variety of options in the toolbox is encouraging within social care where the role of occupational therapists has centred on the provision of equipment and adaptations (Boniface, Mason, Macintyre *et al.*, 2013).

Christiansen, Baum and Bass (2015) assert that a variety of approaches may be used during the stage of intervention in their Person-Environment-Occupation-Performance (PEOP) Model. They present specific terminology for approaches to intervention, summarised in table 8, and evident in this study.

Approach	Key Characteristic
Create-promote	Focus on wellbeing and promoting a balanced lifestyle
Establish-restore	Focus on physiological, neuro-behavioural, cognitive or psychological skills. Re-establishing a lost skill or attaining new skills. Equipment can be provided to support participation
Maintain-habilitate	Focus on maintaining current levels of performance and participation
Modify-compensate	Focus on reducing personal constraints and removing environmental barriers. Equipment and/or adaptations used to compensate for difficulties
Prevent	Focus on limiting impact of anticipated difficulty including preventing a problem by avoiding risk factors
Educate	Focus on the provision of specific knowledge and skills
Consult	Collaboration with service user to mutually define difficulties, identify solutions and enable service user to solve their own difficulties

Advocate	Collaborate with service user to promote changes in policy, procedures and practices.
----------	---

Table 8 Occupational therapy interventions: approaches (Christiansen, Baum and Bass , 2015)

Occupational therapists provided advice on energy conservation, joint protection, and managing cognitive difficulties. These types of advice can be classified under the ‘educate’ approach of occupational therapy interventions in the PEO Model (table 8). Occupational therapists provided specific advice to meet the need of the service user, for example providing joint protection advice to a service user with arthritis affecting his hands. This advice demonstrates the importance of occupational therapists’ experience and knowledge of medical conditions to enable them to provide evidence informed advice. Occupational therapists also provided advice on services available in the community and how to apply for disability benefits. This advice whilst still an educative approach could also be categorised as a ‘create-promote’ approach. Occupational therapists provided advice to support the overall quality of life and wellbeing of the service user.

Occupational therapists demonstrated techniques that can be categorised as ‘establish-restore’ approaches. Occupational therapists analysed the occupation, for example dressing, alongside analysis of the service user’s constraints, for example a fractured wrist. Demonstration of alternative techniques was again supported by experience and knowledge of the techniques demonstrated. In addition to this, occupational therapists did not consider the occupation in isolation. Clear consideration was taken as to routines, including how and when the service user usually undertook the occupation. This was the stage of the intervention when support workers with the reablement service were involved, observing the service user undertaking the task. To enable the re-establishing of routines it is important that support workers can visit at the times that suit the service user. This has implications at the policy/legislation layer of the service as policy would need to support this. In this study on some occasions the independent organisation would not initially agree, for example, to support someone with their personal care in the evening, explaining that this was not their usual practice. This

does not support person centred practice and establishing routines is an important consideration when contracting a reablement service.

6.4.5.1 Providing equipment in reablement

A change in technique by demonstration was not always sufficient to enable the service user to undertake the task. It was at this point that a more focussed assessment of the environment was undertaken to establish if equipment or a minor adaptation would enable the service user to participate in the task. The provision of equipment was a prevalent intervention within the toolbox of interventions of occupational therapists in all of the case studies. Assessment for equipment was an area that colleagues within the wider team sought the contribution of occupational therapists. Equipment was used as an 'establish-restore' approach as described above. Alongside this, it was primarily utilised as a 'modify-compensate' approach. Utilising a person centred approach equipment was offered where it enabled service users to engage in occupations that were important to them. Simple equipment, such as long handled reachers, provided a compensatory approach for someone who could no longer reach down to the floor to pick something up. Raising a bed supported someone to get off the bed more easily when they had reduced strength in their legs.

There is evidence of equipment supporting increased independence of service users (Boniface, Mason, Macintyre *et al.*, 2013; Littlechild, Bowl and Matka, 2010). Studies have found high use of equipment, with data ranging from 78% to 83% of service users using equipment provided to them (Chamberlain, Evans, Neighbour *et al.*, 2001; Sainty, Lambkin and Maile, 2009). This study did not include statistical data on the acceptance and use of equipment by service users. Anecdotally occupational therapists and support workers suggested that most people used the equipment they were given. Comments from support workers in this study suggested that the opinion of families affected whether service users accepted equipment. Family carers have been identified as benefitting from the provision of equipment (Dibsdall and Rugg, 2008; Littlechild, Bowl and Matka, 2010). They have also asserted their wish to provide information and be a resource in the plan for reablement (Hjelle, Alvsvåg and Førland, 2017). Family members influencing use of equipment by service users is a topic that warrants further research.

A finding from this study not highlighted in previous studies on the provision of equipment is the impact of the contextual layer of legislation and policy. The Care Act 2014 (Department of Health, 2014) advocates the use of equipment to support independence and states that service users cannot be charged for equipment. Reablement teams therefore cannot charge for equipment but they can choose not to provide it. In two of the case studies low cost items of equipment such as sock aids were provided to support independence. This was seen as cost effective if it reduced the need for paid support from another person.

This study identified conflict between an occupational therapist's request for equipment to meet a need and organisation policy that has been discussed as being incongruent to a person centred approach (Hammell, 2007). In two of the case study areas occupational therapists in the reablement service asked for equipment, outside of the usual standard stock, that was declined by managers. This led to decreased independence, increased risk and increased care needs. This may link to the protection of individual budgets rather than seeing an overview of all the financial considerations, as the provision of equipment was asserted as a means of reducing needs for support from another person. The timeliness of the provision of equipment was seen as very important, as reablement was designed to be a short term service. Delays in provision of equipment leading to delays in service users moving on to other services has been identified in other reablement studies (Newbronner, Baxter, Chamberlain *et al.*, 2007).

6.5 Occupational Therapists' role as team members

The previous section discussed the role of occupational therapists in reablement represented in the holistic and person centred phase of the conceptual framework. The following sections consider the pre-reablement phase of having a shared purpose, alongside the team approach phase. This section will discuss the impact of the occupational therapists' role with other members of the reablement team. It will include wider theories on teams and the importance of having a shared purpose within a team. The role of occupational therapists providing training and developing trust with support workers is highlighted.

Having a team approach to reablement is a topic that acts at all stages of reablement, as demonstrated with orange boxes throughout all phases of the conceptual framework. The main contexts supporting the team approach were identified as co-location, effective screening and allocation of services users to the most appropriate worker, and attendance at regular meetings of the team. These contexts triggered the mechanisms of communication, trust and collaborative decision leading to positive outcomes for staff and service users. Staff who understood each other's roles could respond to queries and work collaboratively with the service user and their family. Co-location and regular contact supported the team to have a shared purpose. Shared purpose and trust were important for members of the reablement team and service users and carers. Shared purpose will be discussed first whilst trust follows in section 6.5.4.

6.5.1 Shared purpose of reablement

'Shared purpose' is the title of the first phase of the conceptual framework. This phase concerns the importance of a shared purpose, and 'buy in' to that purpose at all contextual layers of the conceptual framework. Occupational therapists described a 'buy in' to the shared purpose of reablement as a service supporting people to be do more for themselves linking the ethos of reablement to the purpose of occupational therapy as described above, section 6.3.1. This section focusses on the occupational therapists' role with service users and members of the reablement team. It also considers the contextual layer of legislation and policy and how it impacts on occupational therapy practice.

6.5.2 Working as one reablement service: co-location and communication

Occupational therapists in this study were clear about their role in reablement and their contribution to assessing the 'whole person'. The first programme theory of the realist synthesis linked the utilisation of the skills of occupational therapists to others recognising their role. Previous studies identified that referrals were made to occupational therapists when a service user was considered as having complex needs (Care Services Efficiency Delivery, 2007; McLeod and Mair, 2009; Rabiee, Glendinning, Arksey *et al.*, 2009). This theory was supported to a lesser degree in this study. The main reason for this is the difference in context. In each of the case

study areas occupational therapists were the main, or one of the main, members of the team that undertook assessments and developed goals and reablement plans with service users and carers; rather than solely a professional group requested by other members of the team when required. Across the three case studies occupational therapists, occupational therapy assistants, social workers, social work assistants and physiotherapists all completed first assessments with service users. The type and complexity of the work determined who might be the most appropriate person to see a service user first. Occupational therapists were selected to assess service users with complex needs, for example, with regards to moving and handling. In another case study a physiotherapist was selected to complete the first assessment for someone who had been discharged from hospital following a fall and resulting fracture, to work on mobility and an exercise plan.

Previous studies have identified the process of a screening referrals both as a method of identifying when a person would benefit from reablement or when support from occupational therapists is indicated (Birkeland, Langeland, Tuntland *et al.*, 2018; Calderdale Council and Yorkshire and Humber Joint Improvement Partnership, 2010; McLeod and Mair, 2009). Similarly, in this study screening and allocation was highlighted as key to supporting service users who were most likely to benefit from reablement, by the person who would best be able to support them. The mechanism identified during the analysis of findings was titled 'Right person, right time'. Knowing each other's roles increased awareness of who would be the best person to assess a service user based on the presenting needs.

Support workers and managers in this study recognised the skills of occupational therapists through working with them. Co-location was confirmed as an important element in getting to know your colleagues. Communication was key to knowing other members of the team in both organisations of the service. Communication ensured clarity between the different roles in the reablement team and enabled recognition of each other's contribution to the team. Staff in other reablement teams have asserted that reablement provides a framework for professional collaboration (Hjelle, Skutle, Førland *et al.*, 2016). They suggested informal lunch meetings as an opportunity to share together. Other studies have identified activities where different staff groups meet, such as through sharing office space or

undertaking joint training, as contexts that support awareness of each other's roles (Baker, Gottschalk, Eng *et al.*, 2001; Nancarrow, 2004). Collaborating in this way has been described as a source of learning, exciting, constructive and promoting well-being in staff (Birkeland, Tuntland, Førland *et al.*, 2017).

In contrast, Elbourne and May's (2015) study of a newly developed multi professional and multi-agency intermediate care service found that poor communication and an uncertainty within the team concerning the model of care being utilised led to the team becoming dysfunctional. Differing ideologies of professionals in the team clashed in certain situations with service users, and personal development of staff was not promoted and this led to poor cohesiveness of the team (Elbourne and le May, 2015). Elbourne and May's (2015) study appears to demonstrate a lack of shared purpose within the team. In addition to interviewing staff, service users were also interviewed and routine data was collected on their progress. An interesting finding was that service users expressed satisfaction with their care and did not appear affected by the poor relationships between staff. Elbourne and May (2015) suggest that staff were using 'emotional labour' (Hochschild, 1983) as a coping mechanism to provide an external positive persona to service users and their families.

6.5.3 Shared purpose and theories of effective teams

A number of authors have included having a shared purpose as an essential element of team working (Adair, 1983; Mickan and Rodger, 2000; West and Markiewkz, 2006). John Adair in considering leadership presents a three circles model (Adair, 1983). He describes the model as simple, yet not simplistic, in that the model consists of three overlapping circles named task, team and individual. The three circles represent the importance of considering the needs of the task, the group and the individuals within the group, respectively. Within the circle of task Adair asserts the need to have a clear task, a common purpose for the team. The needs of the team as a whole is concerned with how different skills are used within the team and the team cohesiveness. Adair (1983) asserts the importance of team members being individuals with their own needs and considering how the team meets their needs. He asserts that leaders should refer to Maslow's hierarchy of needs, for teams to meet the needs of team members. Maslow represents needs in

a familiar pyramid and places physiological and safety needs at the bottom of the pyramid suggesting that this level needs to be met before higher levels of love/belonging, self-esteem and self-actualisation can be met (Maslow, 1943). The level of love/belonging in reablement would relate to the professional relationships between staff and feeling like a member of the team and links to the importance of communication and co-location identified in this study.

Mickan and Rodger (2000) used a systems theory approach to identify the components of effective teams within healthcare. The components were organised into three groups: organisational structure; individual contribution and team processes. The components in the organisational structure section mirror some of Adair (1983): having a clear purpose, distinct roles, and specified task. Other components include having adequate resources and an appropriate culture. Resources and an appropriate culture in terms of the policy of reablement were identified as contextual elements that affected, for example, the provision of equipment as presented above, section 6.4.5.1. Elements of individual contribution are asserted as self-knowledge, trust, commitment and flexibility. Trust is discussed more fully in section 6.5.4. Self-knowledge and commitment link to the members of the team having a shared purpose of reablement and recognition of each other's roles.

Mickan and Rodger (2000) final section concerns team processes. They outline factors of team working, including general attributes between staff: social relationships, communication, coordination and cohesion. They also include more specific tasks of decision making, conflict resolution and feedback on performance. Mickan and Rodger (2005) go on to describe a healthy teams model with four components of team environment, team structure, team processes and individual contribution. Shared purpose, goals, leadership, communication, cohesion and mutual respect were identified as elements that linked across the four components. These elements were seen as important in this study with the exception of leadership that was not identified as a specific factor. Limited references to leadership focussed on the role of managers in approving, or not, the provision of equipment outside of the standard stock, as previously described. However, interviews with participants in this study did not specifically include the topic of

leadership. Therefore it should not be assumed that leadership was not an important factor in other aspects of reablement. Leadership in reablement teams warrants further research.

A healthy reablement team consisting of team members being able to individually contribute to the shared purpose of reablement underpins the ability to share that purpose with service users.

6.5.3.1 Service users' 'buy in' to the ethos of reablement

Shared purpose at the service user and carer layer is concerned with understanding and accepting the purpose and ethos of reablement. An element of the role for occupational therapists in this study was to explain the concept of reablement with service users on hospital wards and in service users' homes. When service users agreed with or 'bought-in' to the ethos of reablement they were actively engaged in reablement. This was particularly pertinent at the stage of service users being discharged from hospital. Occupational therapists asserted that they explained the role of reablement to service users. Despite this, support workers in one case study reported a dissonance between service users' expectations of the reablement team and the actual remit of the reablement service. Examples were provided of service users expecting support workers to do tasks for them, rather than working with the support worker to do more for themselves. Explaining the aim of the reablement service, at what may be a difficult time for service users, may have influenced the service users' acceptance of this information.

Publications have been produced to support staff in discharging patients (service users) from hospital. Lees (2012) provides ten steps to discharging patients. More than one of the steps pertain to communication, involving the patient in their plan for discharge and supporting them to make informed decisions about their responsibilities and support. The Department of Health (2010b) publication on hospital discharge also stresses the importance of informed choices and recommends providing written information. The publication emphasises the role of practitioners to ensure the patient understands the information they have been given. Specific details include encouraging practitioners to demonstrate

compassion and to utilise interpersonal skills to ensure the patient understands the information and provides their informed consent.

Observations of occupational therapists and responses during interviews in this study suggested that occupational therapists utilised many of the suggestions in the documents formerly described. They explained the purpose of reablement, agreed goals with the service user and sought to check understanding. However, no independent checks of understanding were made. A limitation of discussion of this topic in relation to this study is that interviews of service users were not included in this study. Other studies have identified service users describing a lack of awareness of their plan following discharge from hospital in settings, where practitioners asserted that they had provided that information (Strong, 2015). In a study of delayed discharges from hospital, operational staff and service users were interviewed, between four and six months post discharge. Managers in the hospital asserted that service users were involved at all stages of discharge from hospital. At the time of interview the qualitative analysis revealed examples of service users who could recall support given to them at hospital discharge; other comments demonstrated little awareness of the process of being discharged from hospital (Hubbard, Godfrey, Townsend *et al.*, 2008).

Engaging in therapeutic use of self, using interpersonal skills to establish a working relationship with service users, providing information and education may not be sufficient to ensure service users are prepared for their discharge from hospital. Marteau and Weinman (2004) suggest that people process information based on their existing schemata or representations of the situation. Their expectations influence how they deal with new information. If existing schemata conflict and new information is incongruent to the person, Marteau and Weinman (2004) suggest that information needs to be presented in a different way. In relation to reablement if service users have an existing representation of support at home from adult social care as domiciliary carers who visit to do things for you, the approach of reablement would be incongruent with this schemata. In this case further discussion would need to take place. All case studies had leaflets explained the reablement service. Use of case study examples of other people supported by the reablement service within these leaflets may help service users to accommodate

new information into the existing schemata concerning support from adult social care. Leaflets and information on reablement for service users and needs needs to reflect legislation and local policy.

6.5.3.2 Legislation and Policy

Adair (1983) described shared purpose in terms of the team having a common purpose; as an aspect of the task element of his model. Literature on reablement services in this study stated the aim of the service: to support people to gain or regain daily living skills. A second aim of reablement, highlighted in conversations and literature in all case studies, was the aim to reduce the need for ongoing services. Whilst this aim is not included in the definition of reablement, it is not an unexpected finding. Services provided by health and social care organisations services are largely dictated by Acts of Law and guidance, as in the organisational structure element of Mickan and Rodger's (2000) theory of effective teams. Both aims of reablement meet the duties of current legislation. The Care Act (Department of Health, 2014) calls for Local Authorities to work in a person centred way and places a duty on Local Authorities to prevent, reduce and delay need for social care services. Reablement is cited in the statutory guidance to the Care Act (Department of Health, 2017) as a method to meet the duty to prevent, reduce or delay the need for future services. It is to be expected that the duties of the Care Act should be evident in policy and decision making surrounding reablement. Aside from the aims of reablement, the policy surrounding the service also needs to consider the shared purpose. Policy may include consideration of resources, again highlighted in the organisational structure element of Mickan and Rodger (2000) work. Reablement policies impacted on occupational therapy practice in this study. For example delays to the provision of equipment was attributed to reablement policies that called for higher authorisation of item outside of standard stock, that were declined. Policy also determined which service users were suitable for reablement. In this study external pressures affected this policy and this is discussed further below (section 6.5.5.).

In each of the case studies there were two organisations involved in the reablement service. The independent organisation was commissioned by the Local Authority social care commissioners, or the Health and Social Care commissioners jointly in

one instance. Each organisation kept its own identity. For example staff working for the independent organisations wore uniforms with the name of the company on them. A manager of one of the organisations highlighted one of the purposes of their first visit to a service user was to introduce them to the company. The reablement service was explained to service users as a service involving two organisations. The different remit of each organisation did appear to influence practice. For example one organisation worked under a contract that included a target of seeing a certain number of people in a set time period. It was asserted that this organisation were keen to cease working with a service user in order to start supporting another service user, to fulfil their contract quota. This experience was uncomfortable for occupational therapists who stated that they felt rushed to finish working with a service user before they wanted to. This may link to the different working practices of private industry who aim to be profitable and public sector industry who deliver statutory services.

In his text on partnership working Douglas (2009) considers the nature of contracts within health and social care. He asserts that organisations working under contracts for Local Authorities should be seen as partners to enable them to take ownership of the service they are contracted to provide. The professional standards for occupational therapists call for occupational therapists to work collaboratively with colleagues, building positive professional relationships, promoting knowledge, skills and good practice (Royal College of Occupational Therapists, 2017). This highlights the importance of a collaborative approach to decision making across the organisation, that again links to the two organisations providing the one reablement service, having a shared purpose. This practice involves trust, described below, section 6.5.4.

6.5.3.3 The impact of occupational therapists working with support workers

Support workers were the members of the team that had most contact with service users. As such, it is important that support workers understand and 'buy in' to a shared purpose of reablement. The initial programme theory developed from the literature identified two mechanisms triggered by support workers having regular contact with occupational therapists. These mechanisms were the increased skills of support workers and support workers feeling more valued. The context of

regular contact with occupational therapists triggering these mechanisms led to the outcomes of support workers practicing in a reabling way and reporting increased job satisfaction. This programme theory is partially upheld in this study in relation to increased skills of support workers. Increased job satisfaction was highlighted by support workers who compared their role with a previous role of a domiciliary carer working for a care agency. Higher levels of job satisfaction by support workers undertaking a reablement role was not attributed to having contact with occupational therapists, it was attributed to the role itself. Time was the most commonly cited factor leading to increased job satisfaction. Support workers appreciated the flexibility of having more time to support people to do more for themselves, rather than visiting for a specified time period leading them to do things for people. This finding is unsurprising as traditional domiciliary care commissioned on a 'time and task' basis does not provide time for support workers to build a relationship with the service user (Lewis and West, 2014).

The impact of occupational therapists in this study can be attributed to their formal and informal training with support workers. Alongside formal training on working in a reabling way and specific activities such as dressing and demonstrating equipment, occupational therapists also talked informally with support workers in the offices and provided advice and feedback face to face and on the telephone. The importance of training support workers to work in a reabling way, supporting service users rather than 'doing for' service users, has been identified as an important factor in producing positive outcomes in reablement services (Baker, Gottschalk, Eng *et al.*, 2001; Glendinning and Newbrunner, 2008; Tinetti, Baker, Gallo *et al.*, 2002; Winkel, Landberg and Ejlersen Waehrens, 2015). Occupational therapists have been identified as the profession with the necessary skills to train support workers (College of Occupational Therapists, 2010; Skelton, 2013). Occupational therapists themselves have expressed a desire to train support workers and have been involved in training in some settings (Harris, 2010; Latif, 2011; McLeod and Mair, 2009). Occupational therapists in this study undertook training with support workers that included demonstration of equipment and training on different topics such as mobility that reflect training provided in other reablement services (Latif, 2011; Le Mesurier and Cumella, 1999; McLeod and Mair,

2009). Occupational therapists were also involved in assessing the competencies of support workers. From the occupational therapists' perspective, training increased their trust and confidence in the support workers' ability to reable service users. Observation of home visits to assess competencies provided evidence of working in a reabling way. If occupational therapists consider some aspects of the reablement role for support workers within the domain of occupational therapists they may have obligations under the College of Occupational Therapists Code of Ethics (College of Occupational Therapists, 2015a) for delegation of interventions. Section 5.2 of the Code of Ethics reads:

'If you delegate intervention or other procedures you should be satisfied that the person to whom you are delegating is competent to carry them out. In these circumstances, you, as the delegating practitioner, retain responsibility for the occupational therapy care provided to the service user.' (College of Occupational Therapists, 2015 p.33)

This section of the Code of Ethics highlights the need to ensure support workers are competent to carry out tasks. Assessing competencies of support workers would support this.

In this study there was a noticeable difference between levels of training over time that may affect the skill level of support workers and their 'buy in' to the shared purpose of reablement. This subject will be briefly discussed here, with the recognition that the concepts warrant further research.

The reablement teams in this study had all been in practice for less than five years. Both occupational therapists and support workers recalled informal meetings and training provided when the service was set up, in some cases as a smaller pilot study. Comments from support workers who had joined the reablement teams more recently described a noticeably different experience in terms of formal training sessions about reablement. Less formal training was available with training largely consisted of shadowing other workers and learning about equipment and techniques on an individual basis with different service users. A manager in Averdale recognised the need to return to working more closely with

support workers, as had occurred in the early stages of the service, to support a reabling ethos.

This finding has important implications for supporting an ongoing 'buy in' to the ethos of reablement for support workers. Support workers join the reablement team from different backgrounds and experience and standing back rather than delivering care to service users was highlighted as a challenge, particularly initially, for support workers in this study and in others (Baker, Gottschalk, Eng *et al.*, 2001; Rabiee and Glendinning, 2011; Tinetti, Baker, Gallo *et al.*, 2002). Arranging formal training is particularly important for reablement services such as those in this study that include two organisations. Independent organisations registered with the Care Quality Commission to deliver reablement are inspected on the effectiveness of their service and this would include inspecting the training available. Alongside this Local Authorities who commission an organisation to undertake reablement have a responsibility to ensure the organisation has the skills to undertake the service and this has included training to deliver reablement in some areas (Drake and Davies, 2006). Joint training between the two organisations provides an opportunity for staff who work in different locations to come together and get to know each other, further developing confidence and trust between different members of the team.

6.5.4 Building trust between reablement team members

The concept of trust has been mentioned during the discussion of shared purpose particularly between occupational therapists and support workers but this also extends to the wider team and the organisations as a whole. Trust links to the team element of Adair's (1983) model asserting the importance of team cohesiveness and how the skills of different members of the team are used. This latter point is echoed in the individual contribution element of Mickan and Rodger's (2000) theory on effective teams.

Mayer, Davis and Schoorman (1995) describe trust as a willingness to take risks, based on the expectation that the person/service you are trusting will perform an action, whether or not they are able to monitor or control the other party. Mayer, Davis and Schoorman (1995) discuss the trustor's propensity to trust, suggesting

that the stability of this willingness to trust is based on personality and situational factors. They propose a model of trust (reproduced in figure 15) that can be used to illustrate how occupational therapists developed trust in members of the team, particular support workers.

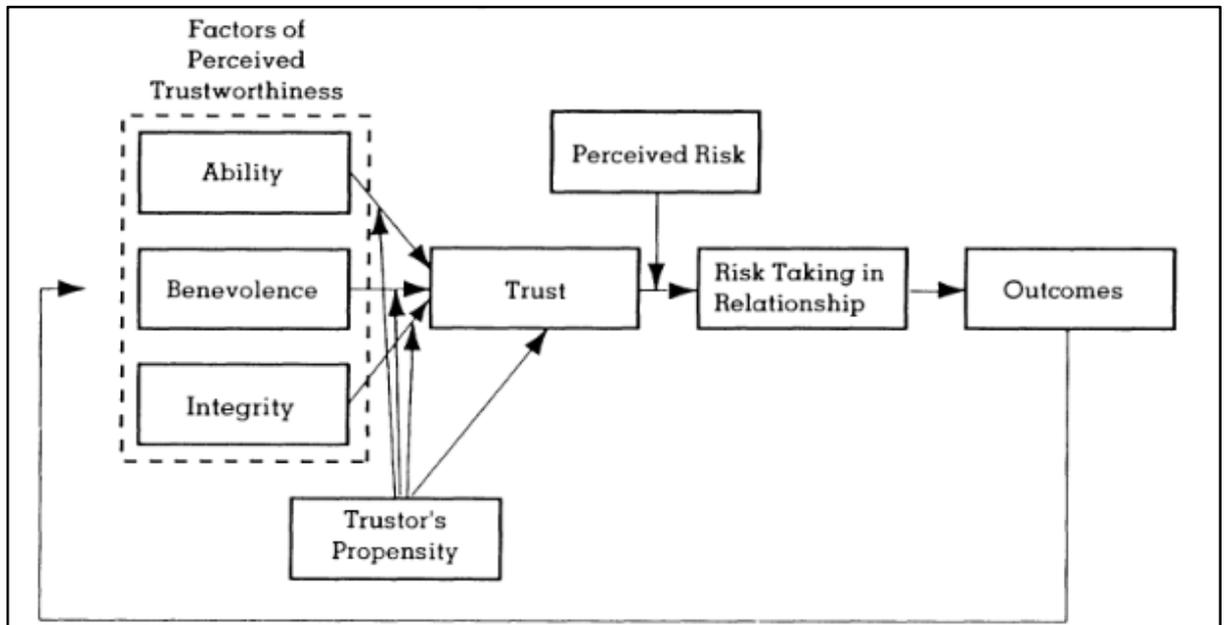


Figure 15 Proposed Model of Trust (Mayer, Davies and Schoorman, 1995, p.715, reproduced with permission of ACADEMY OF MANAGEMENT)

The Model of Trust suggests three factors of perceived trustworthiness: ability, benevolence and integrity. Ability consists of skills, competencies and characteristics within a task and situation specific domain. In this study occupational therapists demonstrated trust in other occupational therapists and professional and trained staff within their own organisation. These staff share a common ground of skills and competencies in the nature of their training and therefore the factor of ability was present supporting the propensity to trust.

The second factor is benevolence. Benevolence concerns the relationship of the trustee to the trustor. It is described as the ‘*extent to which a trustee is believed to want to do good to the trustor*’ (Mayer, Davies and Schoorman, 1995, p.718). It has been described as loyalty, intentions and motives. Reablement teams are Local Government and/or health funded and as such there is no financial gain available to any member of the team such as in other private businesses. Working together led to benevolent working. The third factor of the model, integrity, is described as the trustor’s perception of the trustee abiding to a set of principles accepted by the

trustor as key to the delivery of the intervention or team. This links to having a shared purpose.

Within the Model of Trust, ability, benevolence and integrity are seen as separate elements that contribute to the propensity to trust on a continuum of levels of trust. The propensity to trust can be considered before a relationship begins and can develop over time. In the present study this was evident in the relationship between occupational therapists and support workers. Supporting people to do more for themselves is a principle of reablement that would link to the factor of integrity in this model. Occupational therapists also worked with support workers on developing their skills and competencies in reablement to raise their specific ability in reablement. Occupational therapists in this study did not express concern that support workers had any poor intentions towards occupational therapists that might highlight a lack of benevolence between the two parties. An absence of comments may suggest that benevolence was in place between the two staff groups, although this is written with caution as it cannot be confirmed either way. Occupational therapists did demonstrate a greater propensity to trust support workers who understood this ethos of reablement and who had the skills to undertake the reablement role. The final stage of the model is the outcomes as a result of trusting another party and how that outcome leads you to trust a person more, or less.

Within the reablement context high levels of trust between staff groups is required due to the nature of individual workers supporting people on their own in service users' homes. Whilst occupational therapists felt that reablement was closely aligned to occupational therapy philosophy, this does not exclude other professionals and staff from working in a reablement team. On the contrary, occupational therapists asserted the importance of support workers as the main group of staff working with service users. Inherent requirement for trust within a setting, working within a multidisciplinary and multi-agency set up, could be a factor in occupational therapists' desire to work with support workers to increase their skills and competencies.

The factors of perceived trustworthiness were particularly evident in Averdale as a study that employed support workers within the organisation and worked with

support workers employed by the independent organisation. Support workers working for the health and social care organisation spoke of positive relationships between themselves and the occupational therapists demonstrating benevolence. The support workers were described as understanding and working with the principles of reablement in their practice – demonstrating integrity. The occupational therapists were involved in the training of the support workers and assessed their competencies. This model would suggest that these factors would increase the occupational therapists’ propensity to trust and enable them to take risks in that relationship. Occupational therapists in Averdale utilised these support workers by trusting them to deliver and fit equipment for service users. They reported positive outcomes of this practice and this in turn led to an increased trust between occupational therapists and support workers.

In contrast in Tollbury and Foybrook occupational therapists only worked with support workers employed by the independent organisations. Occupational therapists were less involved in the training of support workers. Whilst occupational therapists often identified working with support workers who were very good, they did not consistently report this to be so. They spoke of a ‘them and us’ situation illustrating a possible lack of confirmation or clarity of benevolence and similarly expressed concern about some support workers not consistently working with the principles of reablement. This demonstrates issues with integrity within the meaning expressed with this model. The ‘them and us’ description is also linked to the contexts illustrated at the organisational level. Occupational therapists shared experiences of the views of the therapists and the views of the organisations not being the same. One reason given was the contracts of the independent organisations, as previously described.

Mayer, Davies and Schoorman’s (1995) Model of Trust can be considered at the organisational layer. A previous survey of Local Authority commissioners identified a lack of trust between Local Authorities and independent organisations (domiciliary care agencies) (Rubery, Grimshaw and Hebson, 2013). Contracts were typically short term and long term relationships between organisations were not formed. A concerning finding was that the Local Authorities that were described as ‘cost minimising’ by commissioning external independent organisations were

also those measuring the least in quality (Rubery, Grimshaw and Hebson, 2013). In this study, in relation to the factors of perceived trustworthiness, both organisations sought to have integrity as the principles of reablement were laid out in, often joint, literature available about the reablement service. Contractual arrangements affected the benevolence between the organisations. The independent organisations were commissioned to provide an element of the reablement service and, in the nature of contractual arrangements, would prioritise considerations of their organisation.

It is the factor of ability that may be key for trust between two agencies. Trust in this instance concerns relationships. Zaheer, McEvily and Perrone (1998) exploring inter-organisational trust asserts that it is individual staff members in organisations who trust, not the organisations themselves. It is not that skills and competencies were not present in the independent organisation, propensity to trust was related to occupational therapists' perceptions that the organisation had the ability to provide reablement. This awareness comes from knowing staff. Support workers often called named occupational therapists that they knew for support. Similarly in settings where occupational therapists co-located with independent organisations they got to know each other, shared information and this increased the propensity to trust one another. This could lead to joint risk taking, for example on decisions about when to reduce support to service users.

A study of intermediate care identified some dysfunction within the team (Elbourne and le May, 2015). Amongst the concerns the researchers discovered some members of the team that had worked together in another setting. These team members demonstrated greater trust and respect for each other. Mutual trust and confidence in each other's abilities is important in interprofessional practice to recognise the need for the contribution of others (Littlechild and Smith, 2013; Mickan and Rodger, 2000). It has been asserted that a key factor in working with members of the team from different professions and job roles is to be confident in your own profession's purpose and principles (Littlechild and Smith, 2013). In this study occupational therapists were clear on their role in reablement. There was evidence of other members of staff also recognising the role of occupational therapists, leading to appropriate requests to work with service users and carers.

6.5.5 The impact of external pressures on the reablement service, 'right service, right time'

A final topic for discussion is included as a theme that is particularly pertinent for health and social care services. It is the consequence of external pressures on an existing service. The conceptual framework illustrates the contexts, mechanisms and interventions that lead to positive outcomes for service users and other members of the reablement team. External pressures, for example to discharge people from hospital, were identified as factors that pushed the boundaries of reablement, and the shared purpose. This occurred when reablement teams were asked to support service users who, in the eyes of the reablement team, required longer term care as opposed to a reablement service.

At the time of the study domiciliary care to support people with ongoing needs was often not available due to local and national shortages of domiciliary care. Occupational therapists and support workers both considered reablement as sometimes used as a 'holding area' for people waiting for the availability of domiciliary care, a practice that has been demonstrated in other literature. Wolstenholme, Monk, McKelvie *et al.* (2007) analysed the literature on health and social care organisations to uncover what they termed 'coping policies' used by health and social care organisations in a climate of an increased demand for services within existing resources. One of their conclusions recommended increasing the provision by social care of domiciliary care and using short term support such as intermediate care and reablement to reduce the level of 'delayed discharges'. Delayed discharge refers to people in hospital who are medically fit but require support to return home, or require alternative accommodation that is not currently available. This evidence suggests an encouragement to use short term services, with perhaps less consideration of the needs of the service user, to reduce costly and often unnecessary stays in hospital. In this study, use of reablement in this way simply delayed the problem as reablement teams were not able to transfer people who needed further support to domiciliary care agencies who did not have the capacity to provide the support required.

During this study both occupational therapists and support workers expressed concern about service users being referred to them who were not appropriate for

reablement, due to their medical condition and reduced potential to improve. Whilst only a small proportion of support workers were observed undertaking their role, those observed including the occupational therapists, were positive and demonstrated a professional approach during visits to service users. This included an observation of a service user who might be defined as not yet appropriate for a reablement service. A first visit was undertaken to a service user discharged from hospital that day. She was unwell and had great difficulty mobilising around her small home. She was readmitted to hospital the following day. It is acknowledged that the actions of the occupational therapists may have been influenced by the presence of the researcher or they may have been demonstrating emotional labour, managing her feelings about the situation and presenting a positive persona for the service user. An alternative suggestion links back to the theory of Goffman (1959) described above. Occupational therapists can be described as presenting their positive and professional approach when in the 'front-stage' of visiting the service user in their own home. In the case of the observed visit, in the back stage (at the office) the occupational therapist expressed concern about the service user's suitability for reablement based on the abilities she had seen. In the 'back stage' she kept regular contact with the support worker who visited. It was the support worker who highlighted the service user's difficulties the next day that led to the readmission to hospital. In this way the 'back stage' of Goffman's (1959) theory was not utilised in terms of relaxing, and stepping away from the character of being an occupational therapist as previous described. The office, rather than being classified as the back-stage perhaps would be better defined as another 'front-stage' or using the same analogy another scene of the same front stage where the occupational therapist was engaged in action concerning the service user, in this case. This action included communication with other team members and taking a collaborative approach to the situation.

A pressure to discharge people from hospital, in this study, led to service users with a variety of needs being referred to reablement. Support workers expressed concern about working with people that they were not sufficiently trained to work for that has been identified by support workers in other reablement services (Harris, 2010). The example given was working with people with a visual impairment. Support

workers were not given training to work with people with visual impairments as service users with those needs were planned to be excluded from the service. This suggests that support workers felt confident only working within a sphere of individual competence related to their training. Occupational therapists did not mirror these concerns. This could be attributed to their higher level of background knowledge, experience and clinical reasoning skills, as described previously. McGray, Palmer and Chmiel (2016) studied the resilience of health and social care teams in light of increasing demand for services whilst dealing with fewer resources. They identified that professionals utilise their professional training as a resilience tool in these situation. This research may explain the absence of comments by occupational therapists in this study as they may have been using their underpinning knowledge and experience to deal with service users with a number of difficulties. The resilience of staff when under pressure warrants further investigation.

6.6 Summary

This chapter has described the formulation of a conceptual framework representing the contexts, mechanism and outcomes that impact on the role of occupational therapists in reablement services. Aspects of the conceptual framework have been discussed throughout the chapter. This chapter has focused on the role of occupational therapists in two key areas: working with service users and as members of the reablement team.

The clear role of occupational therapists in reablement services has been highlighted, including embracing a holistic and person centred approach. This chapter has included the role of occupational therapists in assessment and deciding on goals for reablement within the policy of the reablement service. Clinical reasoning has been proposed as a feature in the analysis of situations and in decision making for reablement intervention. The first section concluded with a discussion of the toolbox of interventions that occupational therapists utilise in reablement services.

The second section of this chapter has considered the role of occupational therapists as members of the reablement team. It has highlighted the importance

of having a shared purpose throughout all the contextual layers of the reablement team including service users and carers, members of the reablement team and the organisation. Contextual factors of communication and co-location have been outlined as important for a reablement team to understand each other's roles and work together. The impact of occupational therapists working with support workers has demonstrated the importance of training and developing trust. The development of trust has been considered in some detail using the Model of Trust as a structure for the discussion (Mayer, Davis and Schoorman, 1995). This chapter has concluded with a brief consideration of the external pressures placed on reablement services, as a public service, and the link to the resilience of staff in this area.

The following chapter will provide a summary of the research and present the contribution of this research to the literature. The chapter will provide personal reflections on use of a realist approach, outline the strengths and limitations of this research and suggest areas for future research.

7 Conclusion

7.1 Introduction

This chapter provides a brief summary of the research and demonstrates how the study met the research questions posed. The chapter includes further reflections on the research process and the strengths and limitations of the study are addressed. The contribution of this research to existing evidence and literature on occupational therapists in reablement services is presented, concluding with recommendations for professional practice and future research.

7.2 Research summary

This thesis commenced with a historical trace of the development of occupational therapy from early practice in hospital settings under medical supervision to working in a person centred way in the community. Tracking this history identified the early use of the word reablement in occupational therapy practice. A discussion of the development of reablement services from recent legislation highlighted the parallels between the purpose of occupational therapy and the aim of reablement.

Existing studies of reablement largely focus on the effectiveness of reablement. The small numbers of occupational therapists included in these studies highlight their role in providing equipment and undertaking additional assessments. It was proposed that occupational therapists have a broader role in reablement services. Studies focused on occupational therapists in reablement are limited to a feasibility study and a short report (Latif, 2011; Whitehead, Walker, Parry *et al.*, 2016). To broaden the understanding of the role of occupational therapists in reablement services, this study focussed on occupational therapists currently practicing in reablement services, and the perspectives of occupational therapists from reablement team members.

This study was approached from a critical realist perspective aiming to understand the underlying mechanisms that impact on occupational therapy practice. A realist synthesis review of the literature identified four programme theories of the role of occupational therapists in reablement services. These included the knowledge of occupational therapy by other members of the team, the holistic approach to

assessment and goal setting by occupational therapists, the provision of equipment, and working with support workers. These theories were tested, refined and expanded through observations, interviews and focus groups with occupational therapists, managers and support workers in three reablement services. Analysis of the data identified two new programme theories related to team working and having a shared purpose.

The previous chapter presented a conceptual framework of contexts and mechanisms that support positive outcomes for service users and support workers in reablement services. As a practitioner I reflected on methods of presentation of my study to other practitioners. The conceptual framework was developed to present a number of contexts and mechanisms that practitioners and managers could consider when commissioning a reablement services. The conceptual framework highlights role of occupational therapists in reablement as holistic and person centred practitioners who use a range of assessments and techniques to work with service users on their goals. The framework also highlights the role of occupational therapists as members of a team involved in formal and informal training with support workers. The following sections present conclusions from this discussion, commencing with a return to the aim and research questions of this research.

7.3 Study aim and research questions

This study aimed to advance the understanding of the role of occupational therapy in reablement services and identify factors influencing practice. The methodology used in this study has supported meeting this aim. The realist synthesis identified potential theories from the literature. The data collection methods of observations, interviews and focus groups provided sufficient data to critically analyse the role of occupational therapists and identify contexts and mechanisms affecting practice.

To recap, the research questions for this study were:

- How can we critically understand the role and impact of occupational therapists working in reablement services?

- What is the experience of occupational therapists working in reablement services, and what contexts and mechanisms affect the outcomes of their practice for service users, carers and members of the reablement team?
- How do reablement managers and support workers work with, and perceive the role of, occupational therapists in reablement services?

The qualitative data collected in the case study phase of this research was an effective method of answering the second and third research questions; contexts mechanism outcome configurations were developed from this data, as presented in the findings chapter. Undertaking observations of occupational therapists provided evidence of the skills and knowledge of occupational therapists and how they work with other members of the team. Scenarios observed were followed up in interviews to clarify situations and discuss the views of the occupational therapist. Interviews and focus groups with managers and support workers provided evidence of their perspective of working with occupational therapists in reablement to some extent. The limitations of short interviews with managers and an inability to recruit support workers in one case study is discussed further below.

The first research question concerned how we can critically understand the role of occupational therapists. Observing and interviewing occupational therapists in the case study element of this research supported this question of methodology. This phase was underpinned by using a realist approach. The next section begins with my reflections on using this approach.

7.4 Critical reflections on using a realist approach

I was introduced to realist research and realist evaluation during the first year of my doctoral studies. As a newcomer to realist research, understanding realist research and the associated terminology were initially a challenge. I opted to follow the approach of Pawson and Tilley; UK researchers who have written extensively concerned the philosophical approach to realist research. Their texts include a detailed description of realist synthesis and realist evaluation that were very welcome to a 'newbie' (Pawson, 2006b; Pawson, 2013; Pawson and Tilley, 1997). These texts were invaluable in improving my understanding and confidence in the approach.

Few research studies have focussed on the role of occupational therapists. Using a realist synthesis approach to the literature allowed gems of information to be gathered from a wide variety of sources to develop potential programme theories of occupational therapy practice. This would not have been possible using a hierarchy of evidence in a systematic review of the literature. A recent systematic review of the literature of the effectiveness of reablement recently found no articles that met the authors' review criteria (Legg, Gladman, Drummond *et al.*, 2016).

As described in chapter two the process of the realist synthesis was an iterative one. The process of identifying and contexts was a time consuming task, making decisions about whether a concept was a context, mechanism or outcome was a challenge that has been highlighted by other researchers (Marchal, van Belle, van Olmen *et al.*, 2012; Punton, Vogel and Lloyd, 2016; Salter and Kothari, 2014). The second literature search of my realist synthesis, to confirm or refute my programme theories, involved choices on the scope of the literature to search from the wide range of literature on occupational therapy. The programme theory concerning the use of equipment by occupational therapists presented straightforward choices for literature searches as the words equipment and terms to represent occupational therapy could be used to identify literature to confirm or refute the programme theory. Other programme theories on assessment, goal setting and working with support workers provided a wide scope of literature. I chose to focus on occupational therapy within the community. I recognise that in limiting literature to this area I may have missed relevant literature. However, I was aware that the case study element of my study would be the main process for confirming or refuting my programme theories

The strength of using a realist approach was the connection of the programme theories to the data collection phase. Using the teacher-learner realist interview technique (described in chapter four) occupational therapists were presented with aspects of the theories to confirm or dispute, alongside answering open questions to identify new theories. This approach revealed a comprehensive picture of the role of occupational therapists in three reablement settings. The realist approach of identifying configurations of contexts, mechanisms and outcomes provided a structure to evaluate the occupational therapists' contribution to reablement.

Utilising other methods, such as a randomised controlled trial, it would not have been possible to identify the varied factors affecting occupational therapists in their role. A benefit of using a realist approach is that the theory generated can be evaluated in future studies using both qualitative and quantitative methods.

Another strength of the realist approach was the identification of contexts and mechanisms at different contextual layers of the service including policy and legislation, the reablement team, occupational therapists and service users and carers. These layers are reflected in the conceptual framework and will support other services to compare the contexts with their setting. This supports commissioners to consider the relevance of the study to practice as suggested by Boaz and Ashby (2003) and, rather than consider the generalisability of the findings, consider as Lincoln and Guba (1985) suggest, the potential transferability of the findings to their setting.

During my studies I was introduced to the RAMESES (Realist And Meta-narrative Evidence Syntheses: Evolving Standards). The RAMESES project was set up to develop the use of realist synthesis and realist evaluation. The RAMESES I project produced training materials (Wong, Westthorp, Pawson *et al.*, 2013) evaluation standards (Wong, Greenhalgh, Westthorp *et al.*, 2014) and publication standards (Wong, Greenhalgh, Westthorp *et al.*, 2013). These materials were published during the course of my study and I was only aware of them once my realist synthesis was in its latter stages. The implications of this is that my realist study was not designed around the training materials or standards. As previously noted I based my study on the publications of Pawson and Tilley (Pawson, 2006b; Pawson and Tilley, 1997). The depth of description in this thesis is evidence of the quality of the research process in this study. Reviewing my study against the RAMESES I evaluation standards, some aspects of my study meet the good criteria such as in my search strategy and consideration of relevant and rigour when reviewing the aspect of the literature of interest to my programme theory. Other aspects are only adequate in relation to not involving commissioners or stakeholders in my review. This latter point relates to being a lone researcher and in the next section I reflect on this aspect of my research journey.

7.5 Reflection on being a practitioner researcher

As a practitioner researcher I was investigating the practice of people in the same profession as myself. At the end of the study I reflect on my approach of using a reflexive diary (as described in chapter four) during identification of programme theories and data analysis. I will also reflect on the strengths and limitations of sharing my role as an occupational therapist with my participants.

During my realist synthesis I was the sole researcher reading the literature and identifying possible programme theories. In some instances mechanisms were identified directly from the text such as the need for timely provision of equipment. In other literature mechanisms were less overt. I was keen to raise my awareness of the influence of my experience as an occupational therapist when identifying mechanisms. I recorded all my initial suggestions of possible mechanisms including my thoughts as a practitioner. I linked each suggestion to supporting evidence from the literature. This ensured my development of programme theories was grounded in the literature rather than my own experience. Despite this I was still the only reviewer of the literature and other reviewers may have identified different programme theories from the literature.

Recording suggestions in this way was useful in latter stages of data analysis as I could see the development of the theories. Recording my reflections on observations and interviews was a useful way of separating my thoughts as a practitioner with the comments of participants in the study. All participants reviewed their interview or focus group transcripts before analysis and an early analysis of one of my interview transcripts was sent to my supervisor for comment. On reflection it would have enhanced this study to include some participants in the analysis stage, returning analysis to participants for discussion. This was not included in the design of the study.

Being an occupational therapist researcher was a strength in gaining rapport with occupational therapists. Occupational therapists saw me as 'one of them'. They regularly reflected on their intervention with service users following visits and in the office. I was able to follow up on these reflections during interviews. Occupational therapists were able to describe their intervention using language

familiar to me, such as trade names for equipment, models of practice and standardised assessments. This enabled the occupational therapists to maintain a flow of conversation during interviews as I infrequently needed to interrupt for the occupational therapists to explain a word or phrase.

An unforeseen negative consequence of disclosing that I am an occupational therapist related to sharing the nature of my role in occupational therapy. During observations with an early participant the occupational therapist asked me about my job. I shared that I was an occupational therapist in the role of team leader, line managing a number of occupational therapists. Following that conversation the occupational therapist made comments such as ‘as a manager you know...’ I reflected that sharing elements of my role influenced how the occupational therapist thought of me, as an occupational therapy manager as well as a researcher. During one joint visit the occupational therapist asked for my opinion on how to deal with a moving and handling situation. I provided advice as the service user was at risk at that point in time. I felt that it would be against my professional code of ethics and professional conduct to not assist a colleague in a clinical situation. Later, I clarified with her that my role was to observe her in practice and I was interested in her perceptions of her role. Reflecting on this experience, with subsequent participants I shared that I was an occupational therapist working in social care, but not in a reablement service; rather than disclosing my role as a team leader. In this way I sought to confirm to the participant that they were the ‘expert’ in this area and my role was to understand their role in reablement from their perspective.

7.6 What this study adds to the literature

My contribution to knowledge in the field of reablement includes the role of holistic and person centred occupational therapists and the importance of a shared purpose of reablement and trust between members of the reablement team.

Findings of this study support the employment of occupational therapists in reablement services. Occupational therapists in this study were committed to the ethos of reablement relating it to the occupational therapy concept of occupational engagement, developing skills and adapting the environment to enable people to

engage in occupations important to them. Occupational therapy education, experience and therapeutic use of self skills were identified as contexts and mechanisms that supported occupational therapists to use a variety of assessment and analysis skill to identify goals of service users. These factors enabled occupational therapists to choose from a toolbox of interventions including giving advice, demonstrating alternative techniques and providing equipment and adaptations.

This study has added to the evidence of important factors in team working. The role of occupational therapists was recognised and sought after by other members of the reablement team. Occupational therapists in this study were involved in training support workers. This included promoting the ethos of reablement, supporting people to do more for themselves. Working with support workers and getting to know them promoted trust between occupational therapists and support workers working for two different organisations. Agreeing and 'buying in' to a shared purpose of reablement between organisations and across all contextual layers enabled a definition of the service for team members and service users. This shared purpose can be flexed with the onset of external pressures, for example expanding the remit of reablement due to pressures to discharge people from hospital. This resulted in training needs for support workers but not for occupational therapists. This suggests that occupational therapists may be more resilient to external pressures, a topic that warrants further research as discussed below.

7.7 Limitations of this study

Qualitative research involves continual construction of the design of the study, rather than following a set process (Maxwell, 2012). This construction within realist research involves prioritising the aspect of the intervention to be studied (Pawson, Greenhalgh, Harvey *et al.*, 2005). The focus of this study was occupational therapists in reablement services. Recruitment of occupational therapists in three case study areas was effective and observations and interviews with occupational therapists resulted in a vast amount of relevant data. Due to the scope of the project participants who could provide a perspective on working with

occupational therapists included support workers and managers. The following provides a reflection on data collection with these groups. This section concludes with reflections on the limited inclusion of service users within the study.

Managers were recruited in each of the case studies. Interviews with managers averaged 22 minutes, half the duration of the average interview with an occupational therapist. A longer reflection on the short duration of these interviews is included in chapter four. Typically managers could only commit a limited time to participating in an interview, reflecting the pressured nature of the service. It was an achievement to obtain an interview with a manager at all. Interviews were held between meetings, during coffee breaks and on one occasion during an organisation's open day. Despite these difficulties managers provided useful information on the context of the reablement service and factors that supported practice.

Chapter four outlines the process of recruiting support workers to participate in the study. Focus groups and interviews were held with support workers in two of the case studies. Despite numerous attempts, it was not possible to recruit support workers to participate in focus groups from the Tollbury case study. During a visit with an occupational therapist to the independent organisation in Tollbury I attended a review meeting where support workers were present. Although this meeting provided scant information of support workers' relationship and view of occupational therapists, it provided an insight into the views and approach of support workers in relation to the service users they worked with.

A limitation of this study is the omission of service users as direct participants. During the realist synthesis phase of the research outcomes were identified for service users such as the holistic practice of occupational therapist increasing the occupational engagement of service users and the use of equipment enabling service users to be independent. Whilst there was some evidence in the literature of these outcomes, including service users in the study would have provided essential data to confirm or refute these theories. Chapter four outlines consideration of including service users in this study and my experience of the first case study I approached declining permission for service users to be participants in the study. On reflection, I recognise that this experience clouded my approach to

the other case studies. My intention was to collect data from the same groups of people in each case study. Following my experience with the first case study I approached I did not approach the other case studies to request permission to include service users. Including service users directly in this research may have identified further contexts, mechanisms and outcomes related to occupational therapists working with them. With permission, one option may have been to invite service users I met during my observation visits to participate in an interview. Two additional programme theories were identified during the data collection phase of this research. Undertaking a full realist evaluation would have involved presenting all relevant theories to service users for their comment using the teacher learner interview technique described in chapter four. However, the timescale of data collection and data analysis was elongated and service users may have had difficulties recalling their experience of working with occupational therapist for a typically short length of time, several months after the event. The inclusion of service users was limited to indirect involvement that provided useful insights of occupational therapists working with service users.

Twenty service users were visited during the observation of occupational therapists. During visits to service users I observed the communication methods and styles of occupational therapists with service users. The visits provided evidence for contexts, mechanisms and outcomes identified by participants in the study. An example of this was a service user who did not understand the role of reablement and expected six weeks of free care. Whilst it was not possible to ascertain service users' views of reablement in this study, this has been evaluated by other authors. A recent qualitative study interviewing eight service users, highlighted motivation as key to service users' engagement in reablement, a factor that was evident in this study (Hjelle, Tuntland, Førland *et al.*, 2017).

7.8 Recommendations for future research

As discussed in chapter two, this study was labelled realist research, rather than a realist evaluation. It was beyond the scope of this exploratory study to evaluate the outcomes identified in the context mechanism outcome configurations using quantitative methodology as recommended in a realist evaluation (Pawson, 2013).

The theory developed from this study provides a basis for future studies both to test outcomes identified and explore topics further. Future studies should include service users and carers as participants, alongside occupational therapists and other team members to test the range of outcomes identified in this study. The previous chapter highlighted the provision of equipment, loneliness in the community, the training of support workers and the resilience of different members of the reablement team as subjects that would benefit from further investigation.

The first topic that would benefit from further qualitative enquiry is the provision of equipment. Support workers suggested that, in their experience, service users may not accept equipment if a family member did not like the appearance or concept of having equipment in their home. As the voice of service users and their family members was not an aspect of this study, this suggestion was not able to be confirmed or refuted. Existing studies evaluating the use of equipment have not identified family members as a constraint to the use of equipment (Chamberlain, Evans, Neighbour *et al.*, 2001; Sainty, Lambkin and Maile, 2009). The influence of family members on the acceptance and use of equipment within reablement services and in wider health and social care teams may benefit from further investigation.

The aims of reablement in the all case studies were to increase the independence of service users and reduce the level of care and support required in the longer term. A consequence of reducing levels of support may lead to loneliness in some service users who benefit from the social aspect of visits from members of the reablement team. Occupational therapist in this study expressed a wish to work with service users on occupations outside the home such leisure pursuits that may build the social engagement of service users and reduce loneliness. Nonetheless, the remit of the service largely restricted goals to occupations within the home. Research comparing longer term outcomes for service users engaging with reablement services with different remits is indicated. Comparing services that support service users with goals to engage in occupations in the community and those restricted to occupations in the home may identify possible difference in levels of loneliness or other quality of life factors.

Formal training and informal support were identified as key to building the skills of support workers to work in a reabling way with service users. It was beyond the scope of this project to evaluate the specific training programmes and compare levels of skills of support workers in each of the case studies. This study identified a difference in levels of training, with formal training provided by the reablement service reducing over time. This has an impact on new support workers joining the reablement service, who potentially receive less training than their colleagues. Providing a regular, comprehensive training programme has resource implications for occupational therapists. A quantitative evaluation of skill levels of support workers following different training programmes would provide evidence to support services to design training programmes to ensure consistency in the support worker role.

One of the results of external pressures on reablement services, for example to discharge people from hospital, was an extension of the remit of the reablement service. This may include working with people not originally intended to be supported by reablement, such as those with a visual impairment. Support workers expressed concern that they did not have sufficient training to work with service users in the extended remit. This concern was not echoed by occupational therapists. The education, knowledge and experience of occupational therapists may be factors enabling them to be more resilient to the extended remit of the service, as found in a study of resilience of professionals in health and social care (McGray, Palmer and Chmiel, 2016). A future exploratory study of working under pressure in reablement services could explore the nature of resilience in different staff groups. This may provide evidence to enable reablement services to support their staff adequately through inevitable external pressures in the current health and social care environment.

7.9 Recommendations for practice

This study identified that occupational therapists' education, skills and experience provide them with a foundation to assess, set goals and choose appropriate intervention to support service users to gain or regain daily living skills. It is recommended that organisations employ occupational therapists in reablement

services to work with service users and carers and to engage in informal and formal training with support workers.

Occupational therapists with skills in different approaches to assessment, establishing rapport and working collaboratively, support person centred goal setting with service users and carers. Organisations should employ occupational therapists with knowledge of a range of interventions including information, advice, demonstration of techniques, and the provision of equipment and adaptations. These skills and knowledge support occupational therapists to choose the most appropriate intervention to promote the independence of service users and potentially reduce the need for future support.

Less experienced occupational therapists working in reablement services may have lesser developed clinical reasoning skills. Regular opportunities for reflection should be encouraged to develop skills in clinical reasoning and for occupational therapists to analyse the evidence base to their practice. It is recognised that person centred goal setting can be a challenge particularly if safety issues are identified. Reflection would also support development of goal setting skills. Additional training specific to goal setting may be beneficial.

The conceptual framework presented in the previous chapter can be used by organisations to consider the different contextual layers of reablement during the design and commissioning of a service. The shared purpose theme in the framework identifies contexts that support the pre reablement phase. At the service user layer, organisations should consider information leaflets for service users to explain the purpose of the service to promote service users' engagement with the aims of reablement. At the policy and legislation layer organisations should ensure policies support the short term nature of reablement. For example, policies concerning the provision of equipment should ensure there is no delay in providing equipment that would support a service user to do more for themselves. Organisations should also contemplate the use of a standardised assessment that demonstrates change both for the organisation and as a motivator for service users and support workers. At the contextual layer of the team, training for support workers including the demonstration of equipment and promoting the ethos of reablement of enabling people to do more for themselves can be met by

occupational therapists through formal and informal support. Organisations should review the ongoing training needs of staff to support consistency in practice.

This study focussed on reablement services consisting of two organisations and there are specific implications for reablement services of this type. Communication and a shared agreement of the remit of reablement is key to promote team working and a shared approach with service users. Regular meetings and joint training fosters trust between members of staff to enable a collaborative 'one service' approach with service users.

7.10 Closing statement

I commenced this study as an occupational therapist, curious about the potential role of occupational therapists in reablement services. American writer Zora Neale Hurston once said 'Research is formalised curiosity. It is poking and prying with a purpose'. Using a realist approach supported poking around for nuggets of information from the literature to identify theory to test during the case study phase.

Prying with a purpose of testing theories identified from the literature enabled the expansion of the original programme theories. The context mechanism outcome configurations and the associated discussion, form a strong base for future studies on reablement and team working.

The case study phase demonstrated the key role of occupational therapists in reablement in assessment, goal setting and using their toolbox of interventions to work with service users in a collaborative way. Occupational therapists practice as members of the team and have a role in working with and training support workers.

Poking and prying in three different reablement services revealed a passionate group of occupational therapists dedicated to reablement. Occupational therapists viewed the aim of reablement as aligned with the purpose of occupational therapy. I finish with a quote from an occupational therapist in Averdale 'everything in reablement is function and that's our job i'nt it!'

References

- Abberley, P. (1995) Disabling Ideology in Health and Welfare - the case of occupational therapy. *Disability and Society* 10 (2) pp. 221-232.
- Adair, J. (1983) *Effective Leadership. A self development manual*. Aldershot: Gower Publishing Company Ltd.
- Allen, K. and Glasby, J. (2010) The (Multi-) Billion Dollar Question: Embedding Prevention and Rehabilitation in English Health and Social Care. *Journal of Integrated Care*. 18 (4) pp. 26-34.
- Alvesson, M. and Sköldbberg , K. (2009) *Reflexive Methodology. New Vistas for Qualitative Research*. London: Sage Publications Ltd.
- Anthony, S. H. (2005) Dr. Herbert J. Hall: originator of honest work for occupational therapy 1904-1923 [part I]. *Occupational Therapy in Health Care*. 19 (3) pp. 3-19.
- Archer, M. (1998) Chapter 7 Introduction Realism in the social sciences. In: Archer, M., Bhaskar, R., Collier, A., Lawson, T. & Norrie, A. (ed.) *Critical Realism Essential Readings*. Abingdon: Routledge.
- Armstrong, S. (2001) Recording and Evaluating Occupational Therapy Outcomes in a Social Services Setting. *Managing Community Care*. 9 (4) pp. 39-43.
- Aspinal, F., Glasby, J., Rostgaard, T., Tuntland, H. and Westendorp, R. G. J. (2016) New horizons: Reablement - supporting older people towards independence. *Age and Ageing*. 45 pp. 574-578.

Audit Commission (2004) *Older People - Independence and Well-being*. Available from: <http://www.housingcare.org/downloads/kbase/1969.pdf> [Accessed 20 October 2017].

Baillie, L. (2015) Promoting and evaluating scientific rigour in qualitative research. *Nursing Standard*. 29 (46) pp. 36-42

Baker, D. I., Gottschalk, M., Eng, C., Weber, S. and Tinetti, M. E. (2001) The design and implementation of a restorative care model for home care. *The Gerontologist*. 41 (2) pp. 257-263.

Ballinger, C. and Wiles, R. (2001) A critical look at evidence-based practice. *British Journal of Occupational Therapy*. 64 (5) pp. 252-255.

Bannigan, K. and Moores, A. (2009) A model of professional thinking: integrating reflective practice and evidence based practice. *Canadian Journal of Occupational Therapy*. 76 (5) pp. 342-350.

Barnes, P. A. and Frock, A. H. (2003) The expanded role for rehabilitation in home care. *Home Health Care Management & Practice*. 15 (4) pp. 305-313.

Bell, L. (2001). Competence in home care. *Quality in Ageing*. 2 (2) pp. 13-20.

Benamy, B. C. (1996) *Developing Clinical Reasoning Skills. Strategies for the Occupational Therapist*. San Antonio: Therapy Skill Builders.

Bhaskar, R. (1978) *A Realist Theory of Science*. London: Verso.

Bhaskar, R. (1998) Chapter 9 Societies In: Archer, M., Bhaskar, R., Collier, A., T., L. & Norrie, A. (ed.) *Critical Realism. Essential Readings*. Abingdon: Routledge.

Birkeland, A., Tuntland, H., Førland, O., Fadnes Jakobsen, F. and Langeland, E. (2017) Interdisciplinary collaboration in reablement - a qualitative study. *Journal of Multidisciplinary Healthcare* [online]. 2017 (10) pp. 195-203. [Accessed 1 July 2018].

Birkeland, A. K., Langeland, E., Tuntland, H., Jacobsen, F. F. and Førland, O. (2018) Hverdagsrehabilitering - integreert eller spesialisert? *Nordisk Tidsskrift for Helseforskning* [online]. 14 (1). [Accessed 1 July 2018]

Boaz, A. and Ashby, D. (2003) *Fit for purpose? Assessing research quality for evidence based policy and practice*. Available from: <https://www.kcl.ac.uk/sspp/departments/politiceconomy/research/cep/pubs/papers/assets/wp11.pdf> [Accessed 10 August 2017].

Boniface, G., Mason, M., Macintyre, J., Synan, C. and Riley, J. (2013) The effectiveness of local authority social services' occupational therapy for older people in Great Britain: a critical literature review. *British Journal of Occupational Therapy*. 76 (12) pp. 538-547.

Borell, L., Nygård, L., Asaba, E., Gustavsson, A. and Hemmingsson, H. (2012) Qualitative approaches in occupational therapy research. *Scandinavian Journal of Occupational Therapy*. 19 (6) pp. 521-529.

Brante, T. (1988) Sociological Approaches to the Professions. *Acta Sociologica*. 31 (2) pp. 119-142.

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*. 3(2) pp.77-101

Bridges, E. and James, V. (2012) *Getting back on your feet: reablement in Wales*. Available from:

http://www.wrvs.org.uk/Uploads/Documents/Reports%20and%20Reviews/getting_back_on_your_feet_reablement_in_wales_report.pdf [Accessed 20 October 2017].

Bright, F. A. S., Boland, P., Rutherford, S. J., Kayes, N. M. and MCpherson, K. M. (2012) Implementing a client-centred approach in rehabilitation: an autoethnography. *Disability and Rehabilitation*. 34 (12) pp. 997-1004.

Bytheway, B., Bacigalupo, V., Bornat, J., Johnson, J. and Spurr, S. (2002) *Understanding care, welfare and community a reader*. Abingdon: Routledge.

Calderdale Council and Yorkshire and Humber Joint Improvement Partnership (2010) *Establishing best practice in reablement: 'people matter'*. Halifax: Calderdale Council.

Canadian Association of Occupational Therapists (1997) *Enabling occupation: an occupational therapy perspective*. Ottawa: CAOT Publications ACE.

Care Quality Commission (2018) *Key lines of enquiry for adult social care*. Available from: <https://www.cqc.org.uk/guidance-providers/adult-social-care/key-lines-enquiry-adult-social-care-services> [Accessed 23 June 2018].

Care Services Efficiency Delivery (2007) *Homecare re-ablement workstream: discussion document HRA 002* [online]. London: Department of Health. Available from: http://www.csed.dh.gov.uk/_library/Resources/CSED/DiscussionDoc/HRADiscDoc_Latest_NEW_FORMAT.pdf [Accessed 1 December 2013].

Care Services Efficiency Delivery (2010) *Homecare Re-ablement CSSR Scheme Directory Update November 2010*. London: Department of Health.

Care Services Efficiency Delivery (2012) *Homecare Re-ablement CSSR Scheme Directory Update November 2012* [online]. New Malden: Gerald Pilkington Associates. Available from: http://www.gerald Pilkington Associates.com/js/plugins/filemanager/files/Homecare_Re-ablement_Scheme_Directory_Update_April_2012.pdf [Accessed 20 October 2017].

Carrier, A., Levasseur, M., Bédard, D. and Desrosiers, J. (2012) Clinical reasoning process underlying choice of teaching strategies: A framework to improve occupational therapists' transfer skill interventions. *Australian Occupational Therapy Journal*. 59 (5) pp. 355-366.

Chamberlain, E., Evans, N., Neighbour, K. and Hughes, J. (2001) Equipment: is it the answer? An audit of equipment provision. *British Journal of Occupational Therapy*. 64 (12) pp. 595-600.

Chana, R., Marshall, P. and Harley, C. (2016) The role of the intermediate care team in detecting and responding to loneliness in older clients. *British Journal of Community Nursing*. 21 (6) pp. 292-298.

Charlton, F., Bone, L. and Billing, R. (2015) Devon pilot project assessing double handed community care, a truly personalised approach...39th annual conference and exhibition of the College of Occupational Therapists, Brighton and Sussex, England. June 30-July 2, 2015. *British Journal of Occupational Therapy*. 78 pp. 14-15.

Cheyne, H., Abhyankar, P. and McCoury, C. (2013) Empowering change: Realist evaluation of a Scottish Government programme to support normal birth. *Midwifery*. [online] 29 pp. 1110-1121. [Accessed 5 May 2017]

Chinouya, M. and Cook, M. (2012) How reablement can be good for care staff as well as service users. *Community Care* [online]. 16.12.12 . Available from: <http://www.communitycare.co.uk/articles/19/12/2012/118783/how-reablement-can-be-good-for-care-staff-as-well-as-service-users.htm> [Accessed 5 February 2016].

Christiansen, C. H., Baum, C. M. and Bass, J. D. (2015) *Occupational Therapy Performance, Participation and Well-Being*. NJ: Slack Incorporated.

Clark, F. A. (2010) Power and confidence in professions: Lessons for occupational therapy. *Canadian Journal of Occupational Therapy*. 77 (5) pp. 264-269.

Classen, S., Winter, S., Monahan, M., Yarney, A., Link Lutz, A., Platek, K. and Levy, C. (2017) Driving Intervention for Returning Combat Veterans: Interim Analysis of a Randomized Controlled Trial. *OTJR: Occupation, Participation and Health*. 37 (2) pp. 62-71.

Clouston, T. J. and Whitcombe, S. W. (2008) The professionalisation of occupational therapy: a continuing challenge. *British Journal of Occupational Therapy*. 71 (8) pp. 314-320.

Cohen, L., Manion, L. and Morrison, K. (2018) *Research methods in education*. London: Routledge.

Colin, C., Wade, D. T., Davies, S. and Horne, V. (2008) The Barthel Index. *Disability and Rehabilitation*. 10 (2) pp. 61-63.

College of Occupational Therapists (2010) *Position Statement: Reablement: the added value of Occupational Therapists*. London: College of Occupational Therapists.

College of Occupational Therapists (2014) *College of Occupational Therapists' learning and development standards for pre-registration education*. London: College of Occupational Therapists.

College of Occupational Therapists (2015a) *Code of Ethics and Professional Conduct for Occupational Therapists*. London: College of Occupational Therapists.

College of Occupational Therapists (2015b) *Research Guide: Evidence-based/evidence-informed practice*. London: Royal College of Occupational Therapists.

Collier, A. (1994) *Critical Realism. An Introduction to Roy Bhaskar's Philosophy*. London: Verso.

Conneeley, A. L. (2002) Methodological Issues in Qualitative Research for the Researcher/Practitioner. *British Journal of Occupational Therapy*. 65 (4) pp. 185-190.

Corbetta, P. (2003) *Social research: theory, methods and techniques*. London: Sage Publications.

Craddock, J. (1996a) Responses of the occupational therapy profession to the perspective of the disability movement, Part 1. *British Journal of Occupational Therapy*. 59 (1) pp. 17-22.

Craddock, J. (1996b) Responses of the occupational therapy profession to the perspective of the disability movement, Part 2. *British Journal of Occupational Therapy*. 59 (2) pp. 73-8.

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I. and Petticrew, M. (2006) *Developing and evaluating complex interventions: new guidance*. Available from: <https://www.mrc.ac.uk/documents/pdf/complex-interventions-guidance/> [Accessed 4 September 2017].

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I. and Petticrew, M. (2008). Developing and evaluating complex interventions: the new Medical Research Council guidance. *British Medical Journal* [online]. 2008; 337:a1655. Available from: <https://www.bmj.com/content/337/bmj.a1655> [Accessed: 5 July 2018]

Creek, J. (1997) ...the Truth is No Longer Out There. *British Journal of Occupational Therapy*. 60 (2) pp. 50-52.

Creek, J. (2003) *Occupational therapy defined as a complex intervention*. London: College of Occupational Therapists.

Creek, J. (2010) *The Core Concepts of Occupational Therapy: A Dynamic Framework for Practice*. London: Jessica Kingsley Publishers.

Creek, J., Ilott, I., Cook, S. and Munday, C. (2005) Valuing occupational therapy as a complex intervention. *British Journal of Occupational Therapy*. 68 (6) pp. 281-284.

Creek, J. and Lawson-Porter, A. (2007) *Contemporary Issues in Occupational Therapy. Reasoning and Reflection*. Chichester: John Wiley and Sons Ltd.

Creswell, J. W. (1998) *Qualitative Inquiry and Research Design, Choosing Among Five Traditions*. London: Sage Publications.

Crotty, M. (1998) *The Foundations of Social Research: Meaning and Perspective in the Research Process*. London: Sage Publications.

Cutcliffe, J. R. and McKenna, H. P. (1999) Establishing the credibility of qualitative research findings: the plot thickens. *Journal of Advanced Nursing*. 30 (2) pp. 374-380.

Dalkin, S. M., Greenhalgh, J., Jones, D., Cunningham, B. and Lhussier, M. (2015) What's in a mechanism? Development of a key concept in realist evaluation. *Implementation Science*. 10 (49).

Danermark, B., Ekstrom, M., Jakobsen, L. and Karlsson, J. C. (2002) *Explaining Society. Critical Realism in the Social Sciences*. London: Routledge.

Danks, M. and Toland, H. (2017) How occupational therapy core skills can achieve real savings for local authorities...RCOT (Royal College of Occupational Therapist)

Annual Conference 2017. *British Journal of Occupational Therapy*. 80 (8 suppl.) pp. 86-87.

Darawsheh, W. (2014) Reflexivity in research: Promoting rigour, reliability and validity in qualitative research. *International Journal of Therapy & Rehabilitation*. 21 (12) pp. 560-568 9p.

Dayson, C., Bashir, N. and Pearson, S. (2013) *From dependence to independence: emerging lessons from the Rotherham Social Prescribing Pilot. Summary Report*. Sheffield: Sheffield Hallam University. Centre for Regional Economic and Social Research.

Denzin, N. K. and Lincoln, Y. S. (1998) *The Landscape of Qualitative Research: Theories and Issues*. Thousand Oaks: Sage Publications.

Department of Health (1990) *The National Health Service and Community Care Act*. London: HMSO.

Department of Health (2001) *Research Governance Framework for Health and Social Care*. London: Department of Health.

Department of Health (2005) *The Mental Capacity Act*. London: HMSO.

Department of Health (2007) *Putting People First. A shared vision and commitment to the transformation of Adult Social Care*. London: Department of Health.

Department of Health (2009) *Transforming Adult Social Care LAC (DH) (2009)*. London: Department of Health.

Department of Health (2010a) *Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care. Guidance on Eligibility Criteria for Adult Social Care, England 2010*. London: Department of Health.

Department of Health (2010b) *Ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care*. London: Department of Health.

Department of Health (2010c) *A Vision for Adult Social Care: Capable Communities and Active Citizens*. London: Department of Health.

Department of Health (2014) *Care Act 2014*. London: Department of Health.

Department of Health (2017) *Care and support statutory guidance* [online]. Available from: <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance> [Accessed 16 September 2017].

Department of Health and Social Security (1970) *The Chronically Sick and Disabled Persons Act 1970 - DHSS 70(12)*. London: Department of Health and Social Security.

Department of Health Social Care Policy and Innovation (2010) *Improving care and saving money: learning the lessons on prevention and early intervention for older people*.

Dibsdall, L. and Rugg, S. (2008) Carers' perspectives on their needs and local authority occupational therapy practice. *British Journal of Occupational Therapy*. 71 (7) pp. 277-285.

Dixon-Woods, M., Agarwal, S., Jones, D., Young, B. and Sutton, A. (2005) Synthesising qualitative and quantitative evidence: a review of possible methods. *Journal of Health Services Research and Policy*. 10 (1) pp. 45-53.

Douglas, A. (2009) *Partnership Working*. Abingdon: Routledge.

Doumanov, P. and Rugg, S. (2003) Clinical reasoning skills of occupational therapists and support staff: a comparison. *International Journal of Therapy and Rehabilitation*. 10 (5) pp. 195-203.

Drake, P. R. and Davies, B. M. (2006) Home care outsourcing strategy. *Journal of Health, Organisation and Management*. 20 (3) pp. 175-193.

Elbourne, H. F. and le May, A. (2015) Crafting intermediate care: one team's journey towards integration and innovation. *Journal of Research in Nursing*. 20 (1) pp. 56-71.

Ely, M., Vinz, R., Downing, M. and Anzul, M. (1997) *On Writing Qualitative Research: Living by Words*. London: Falmer Press.

Emerson, R. M., Fretz, R. I. and Shaw, L. (2011) *Writing Ethnographic Fieldnotes*. Chicago: University of Chicago Press.

Emmel, N. (2015) *I'm not dancing, I'm zigzagging* [online]. Available from: <https://realistmethods.files.wordpress.com/2015/03/im-not-dancing-im-zigzagging.pdf> [Accessed 15 December 2015].

Evans, D. (2003) Hierarchy of evidence: a framework for ranking evidence evaluating healthcare interventions. *Journal of Clinical Nursing*. 12 (1) pp. 77-84.

Fawcett, B., Fillingham, J., River, D., Smojkis, M. and Ward, N. (2018) *Service User and Carer Involvement in Health and Social Care. A Retrospective and Prospective Analysis*. London: Palgrave.

Finch, J. (1987) The Vignette Technique in Survey Research. *Sociology*. 21 (1) pp. 105-114.

Finlay, L. (1998) Reflexivity: an Essential Component for All Research? *British Journal of Occupational Therapy*. 61 (10) pp. 453-456.

Finlay, L. (2000) Multiple Voices, Multiple Paths: Choosing between Qualitative Traditions. *British Journal of Occupational Therapy*. 63 (12) pp. 580-582.

Finlay, L. (2001) Holism in Occupational Therapy: Elusive Fiction and Ambivalent Struggle. *American Journal of Occupational Therapy*. 55 (3) pp. 268-276.

Finlay, L. (2002a) Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative Research*. 2 (2) pp. 209-230.

Finlay, L. (2002b) "Outing" the Researcher: the Provenance, Process, and Practice of Reflexivity. *Qualitative Health Research*. 12 (4) pp. 531-545.

Finlay, L. (2006a) Chapter 2 Mapping Methodology. In: Finlay, L. & Ballinger, C. (ed.) *Qualitative Research for Allied Health Professionals: Challenging Choices*. Chichester: Whurr Publishers Ltd.

Finlay, L. (2006b) 'Rigour', 'ethical integrity' or 'artistry'? Reflexively reviewing criteria for evaluating qualitative research. *British Journal of Occupational Therapy*, 69(7), July 2006, pp.319-326.

Finlay, L. and Ballinger, C. (2006) *Qualitative Research for Allied Health Professionals: Challenging Choices*. Chichester: Whurr Publishers Limited.

Fisher, G. S., Baker, A., Koval, D., Lishok, C. and Maisto, E. (2007) A field test of the Cougar Home Safety Assessment (version 2.0) in the homes of older persons living alone. *Australian Occupational Therapy Journal*. 54 pp. 124-130.

Fleming, M. H. (1991) The Therapist With the Three-Track Mind. *American Journal of Occupational Therapy*. 45 (11) pp. 1007-1014.

Foster, M., Harris, J., Jackson, K., Morgan, H. and Glendinning, C. (2006) Personalised social care for adults with disabilities: a problematic concept for frontline practice. *Health & Social Care in the Community*. 14 (2) pp. 125-135.

Frank, G. and Polkinghorne, D. (2010) Qualitative Research in Occupational Therapy: From the First to the Second Generation. *OTJR: Occupation, Participation and Health*. 30 (2) pp. 51-57.

Freidson, E. (1986) *Professional Powers A Study of the Institutionalization of Formal Knowledge*. Chicago: The University of Chicago Press.

Freshwater, D. (2005) Chapter 12: Action research for changing and improving practice. In: Holloway, I. (ed.) *Qualitative research in health care*. Maidenhead: Open University Press.

Gearing, R. E. (2004) Bracketing in Research: A Typology. *Qualitative Health Research*. 14 (10) pp. 1429-1452.

George, A. L. and Bennett, A. (2005) *Case Studies and Theory Development in the Social Sciences*. Cambridge, Massachusetts: MIT Press.

Gerald Pilkington Associates (2012) *The cost effectiveness of homecare re-ablement: a discussion paper to explore the conclusions that can be drawn from the body of evidence*. Gerald Pilkington Associates.

Gibson, D., Velde, B., Hoff, T., Kvashay, D., Manross, P. L. and Moreau, V. (2000) Clinical Reasoning of a Novice versus an Experienced Occupational Therapist: A Qualitative Study. *Occupational Therapy in Health Care*. 12 (4) pp. 15-31.

Glendinning, C., Jones, K., Baxter, K., Rabiee, P., Curtis, L. A., Wilde, A., Arkey, H. and Forder, J. E. (2010) *Home care re-ablement services: investigating the longer-term impacts (prospective longitudinal study)*. University of York. Social Policy Research Unit.

Glendinning, C. and Newbrunner, E. (2008) The effectiveness of home care reablement -- developing the evidence base. *Journal of Integrated Care*. 16 (4) pp. 32-39.

- Goffman, E. (1959) *The Presentation of Self in Everyday Life*. USA: Anchor Books.
- Greenhalgh, T., Humphrey, C., Hughes, J., MacFarlane, F., Butler, C. and Pawson, R. (2009) How Do You Modernize a Health Service? A Realist Evaluation of Whole-Scale Transformation in London. *The Milbank Quarterly*. 87 (2) pp. 391-416.
- Greenwood-Lee, J., Hawe, P., Nettel-Aguirre, A., Shiell, A. and Marshall, D. A. (2016) Complex intervention modelling should capture the dynamics of adaptation. *BMC Medical Research Methodology*. 16 (1) pp. 1-7.
- Hagedorn, R. (2001) *Foundations for Practice in Occupational Therapy*. Edinburgh: Churchill Livingstone.
- Hammell, W. K. (2007) Client-centred Practice: Ethical Obligation or Professional Obfuscation? *British Journal of Occupational Therapy*. 70 (6) pp. 264-266.
- Harding, T. (1997) *A life worth living: the independence and inclusion of older people*. Help the Aged.
- Harris, A. (2010) *East Dorset Re-ablement Pilot Evaluation*. Dorset County Council.
- Health and Care Professions Council (2013a) *Professions Occupational Therapist*. Available from: <http://www.hcpc-uk.co.uk/aboutregistration/professions/index.asp?id=6> [Accessed 10 May 2017].
- Health and Care Professions Council (2013b) *Standards of proficiency. Occupational therapists*. London: Health and Care Professions Council.
- Health and Safety Executive (2004) *Manual handling: manual handling operations regulations 1992 (as amended). Guidance on regulations (L23)*. London: Health and Safety Executive.

Hjelle, K. M., Alvsvåg, H. and Førland, O. (2017) The relatives' voice: how do relatives experience participation in reablement? A qualitative study. *Journal of Multidisciplinary Healthcare* [online]. 10 pp. 1-11. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5207447/> [Accessed 30 May 2018]

Hjelle, K. M., Skutle, O., Førland, O. and Alvsvåg, H. (2016) The reablement team's voice: a qualitative study of how an integrated multidisciplinary team experiences participation in reablement. *Journal of Multidisciplinary Healthcare* [online]. 9 pp. 575-585. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5098780/> [Accessed 30 May 2018]

Hjelle, K. M., Tuntland, H., Førland, O. and Alvsvåg, H. (2017) Driving forces for home-based reablement; a qualitative study of older adults' experiences. *Health & Social Care in the Community*. 25 (5) pp. 1581-1589.

HM Stationery Office (1973) *NHS Reorganisation Act 1973 Clause 18(4)(b)* London: HM Stationery Office.

Hochschild, A. R. (1983) *The managed heart: commercialization of human feeling*. University of California Press.

Hocking, C. (2007) Early Perspectives of Patients, Practice and the Profession. *British Journal of Occupational Therapy*. 70 (7) pp. 284-291.

Hocking, C. (2008a) The way we were: romantic assumptions of pioneering occupational therapists in the United Kingdom. *British Journal of Occupational Therapy*. 71 (4) pp. 146-154.

Hocking, C. (2008b) The way we were: the ascendance of rationalism. *British Journal of Occupational Therapy*. 71 (6) pp. 226-233.

Hocking, C. (2008c) The way we were: thinking rationally. *British Journal of Occupational Therapy*. 71 (5) pp. 185-195.

Hocking, C. and Nicholson, E. (2007) Chapter 3: Occupation for occupational therapists: how far will we go? In: Creek, J. & Lawson-Porter, A. (ed.) *Contemporary Issues in Occupational Therapy: Reasoning and Reflection*. Chichester: John Wiley and Sons Ltd.

Hocking, C., Pierce, D., Shordike, A., Wright-St Clair, V., Bunrayong, W., Vittakakorn, S. and Rattakorn, P. (2008) The Promise of Internationally Collaborative Research for Studying Occupation: The Example of the Older Women's Food Preparation Study. *OTJR: Occupation, Participation and Health*. 28 (4) pp. 180-190.

Hollis, V., Openshaw, S. and Goble, R. (2002) Conducting focus groups: purpose and practicalities. *British Journal of Occupational Therapy*. 65 (1) pp. 2-8.

Holloway, I. (2005) *Qualitative Research in Health Care*. Maidenhead: Open University Press.

Horowitz, B. P., Nochajski, S. M. and Schweitzer, J. A. (2013) Occupational Therapy Community Practice and Home Assessments: Use of the Home Safety Self-Assessment Tool (HSSAT) to Support Aging in Place. *Occupational Therapy in Health Care*. 27 (3) pp. 216-227.

Houghton, C., Casey, D., Shaw, D. and Murphy, K. (2013) Rigour in qualitative case-study research. *Nurse Researcher*. 20 (4) pp. 12-17 6p.

Housing Act 1974. Ch. 44 (1974) London: HMSO.

Houston, S. (2001) Beyond Social Constructionism: Critical Realism and Social Work. *British Journal of Social Work*. 31 (6) pp. 845-861.

Hubbard, G., Godfrey, M., Townsend, J., Cornes, M., Donaghy, E. and Manthorpe, J. (2008) *Reimbursement in practice: the last piece of the jigsaw?* University of Stirling, University of Leeds, Kings College London.

Hübner, L. (2014) Constructing relations in social work: client, customer and service user? The application and relevance of the term user in social work discourse. *Nordic Social Work Research*. 4 (2) pp. 87-98.

Hudon, C., Fortin, M., Rossignol, F., Bernier, S. and Poitras, M. E. (2011) The Patient Enablement Instrument - French version in a family practice setting: a reliability study. *BMC Family Practice*. 12 (71).

Jackson, L., Langille, L., Lyons, R., Hughes, J., Martin, D. and Winstanley, V. (2009) Does moving from a high-poverty to lower-poverty neighborhood improve mental health? A realist review of 'Moving to Opportunity'. *Health and Place*. 15 pp. 961-970.

James, S. and Corr, S. (2004) The Morriston Occupational Therapy Outcome Measure (MOTOM): Measuring What Matters. *British Journal of Occupational Therapy*. 67 (5) pp. 210-216.

Jones, K., Baxter, K., Curtis, L., Arksey, H., Forder, J., Glendenning, C. and Rabiee, P. (2009) *The short-term outcomes and costs of re-ablement services: prospective longitudinal study: interim report* York: Social Policy Research Unit, University of York.

Kemp, S. (2005) Critical Realism and the Limits of Philosophy. *European Journal of Social Theory*. 8 (2) pp. 171-191.

Kent, J., Payne, C., Stewart, M. and Unell, J. (2000) *External Evaluation of the Home Care Reablement Pilot Project (Leicestershire County Council)*. Leicester: DeMontfort University.

Kielhofner, G. (2002) *Model of Human Occupation: Theory and Application*. Baltimore: Lippincott Williams and Wilkins.

Kilgarriff-Foster, A. and O'Cathain, A. (2015) Exploring the components and impact of social prescribing. *Journal of Public Mental Health*. 14 (3) pp. 127-134.

Kimberlee, R. (2016) What is the value of social prescribing? *Advances in Social Sciences Research Journal*. 3 (3) pp. 29-35.

King, A. I., Parsons, M., Robinson, E. and Jörgensen, D. (2012) Assessing the impact of a restorative home care service in New Zealand: a cluster randomised controlled trial. *Health & Social Care in the Community*. 20 (4) pp. 365-374.

Kings Fund (2017) *What is social prescribing?* Available from: <https://www.kingsfund.org.uk/publications/social-prescribing> [Accessed 23 June 2018].

Kitzinger, J. (1994) The methodology of Focus Groups: the importance of interaction between research participants. *Sociology of Health and Illness*. 16 (1) pp. 103-121.

Kreftling, L. (1991) Rigor in Qualitative Research: The Assessment of Trustworthiness. *American Journal of Occupational Therapy*. 45 (3) pp. 214-222.

Kuipers, K. and Grice, J. W. (2009) The structure of novice and expert occupational therapists' clinical reasoning before and after exposure to a domain-specific protocol. *Australian Occupational Therapy Journal*. 56 (6) pp. 418-427.

Lacouture, A., Breton, E., Guichard, A. and Ridde, V. (2015) The concept of mechanism from a realist approach: a scoping review to facilitate its operationalization in public health program evaluation. *Implementation science*. 10 (1) pp. 153-163.

Latif, Z. (2011) *Cost benefit analysis of the Occupational Therapist's impact on reablement in Nottingham city*. Nottingham: Nottingham City Council.

Law, M. C. and MacDermid, J. (2013) *Evidence-based rehabilitation: a guide to practice*. 3rd edition. Thorofare, NJ: Slack.

Le Mesurier, N. and Cumella, S. (1999) Enhancing independence: the effectiveness of re-ablement provision in South Worcestershire. *Managing Community Care*. 7 (4) pp. 27-32.

Leech, N.L. and Onwuegbuzie, A.J. (2011) Beyond Constant Comparison Qualitative Data Analysis: Using NVivo. *School Psychology Quarterly*. 26(1) pp.70-84

Lees, L. (2012) *Timely discharge from hospital*. Keswick, Cumbria: M&K Update Ltd.

Legg, L., Gladman, J., Drummond, A. and Davidson, A. (2016) A systematic review of the evidence on home care reablement services. *Clinical Rehabilitation*. 30 (8) pp. 741-749.

Lewin, G., Calver, J., McCormack, B., Coster, C., O'Connell, H., Wheeler, B., Smith, J. and Vandermeulen, S. (2008) The Home Independence Project. *Geriatrics*. 26 (3) pp. 13-20.

Lewin, G., De San Miguel, K., Knuiman, M., Alan, J., Boldy, D., Hendrie, D. and Vandermeulen, S. (2013) A randomised controlled trial of the Home Independence Program, an Australian restorative home-care programme for older adults. *Health and Social Care in the Community*. 21 (1) pp. 69-78.

Lewin, G. and Vandermeulen, S. (2010) A non-randomised controlled trial of the Home Independence Program (HIP): An Australian restorative programme for older home care clients. *Health and Social Care in the Community*. 18 (1) pp. 91-99.

Lewis, J. and West, A. (2014) Re-Shaping Social Care Services for Older People in England: Policy Development and the Problem of Achieving 'Good Care'. *Journal of Social Policy*. 43 (1) pp. 1-18.

Lincoln, Y. S. and Guba, E. G. (1985) *Naturalistic inquiry*. London: Sage Publications.

Linsley, P., Howard, P. and Owen, S. (2015) The construction of context-mechanisms-outcomes in realistic evaluation. *Nurse researcher*. 22 (3) pp. 28-34.

Littlechild, B. and Smith, R. (2013) *A Handbook of Interprofessional Practice in the Human Sciences. Learning to work together*. Harlow, Essex: Pearson Education Ltd.

Littlechild, R., Bowl, R. and Matka, E. (2010) An independence at home service: the potential and the pitfalls for occupational therapy services. *The British Journal of Occupational Therapy*. 73 (6) pp. 242-250.

Local Authority Social Services Act 1970. Ch 42 (1970) London: HMSO.

London-Willis, J., Couldrick, L. and Lovelock, L. (2012) The personalisation of adult social care: occupational therapists' perceptions. *British Journal of Occupational Therapy*. 75 (3) pp. 128-133.

MacDonald, E. M. e. (1964) *Occupational Therapy in Rehabilitation*. London: Baillière, Tindall and Cox.

Marchal, B., van Belle, S., van Olmen, J., Hoérée, T. and Kegels, G. (2012) Is realist evaluation keeping its promise? A review of published empirical studies in the field of health systems research. *Evaluation*. 18 (2) pp. 192-212.

Marteau, T. M. and Weinman, J. (2004) Chapter 10 Communicating about health threats and treatments. In: Sutton, S., Baum, A. & Johnston, M. (ed.) *The SAGE Handbook of Health Psychology*. London: SAGE Publications.

- Masala, C. and Petretto, D. R. (2008) From disablement to enablement: Conceptual models of disability in the 20th century. *Disability and Rehabilitation*. 30 (17) pp. 1233-1244.
- Maslow, A. H. (1943) A theory of human motivation. *Psychological Review*. 50 (4) pp. 370-396.
- Mattingly, C. and Fleming, M. H. (1994) *Clinical Reasoning Forms of Inquiry in a Therapeutic Practice*. Philadelphia: F.A. Davis Company.
- Maxwell, J. A. (2012) *A realist approach for qualitative research*. London: SAGE Publications.
- Mayer, R. C., Davis, J. H. and Schoorman, F. D. (1995) An Integrative Model of Organizational Trust. *The Academy of Management Review*. 20 (3) pp. 709-734.
- Mayers, C. A. (1993) A Model for Community Occupational Therapy Practice, Stage 1. *British Journal of Occupational Therapy*. 56 (5) pp. 169-172.
- Mays, N., Pope, C. and Popay, J. (2005) Systematically reviewing qualitative and quantitative evidence to inform management and policy-making in the health field. *Journal of Health Services Research and Policy*. 10 (Suppl 1) pp. 6-20.
- McGray, J., Palmer, A. and Chmiel, N. (2016) Building resilience in health and social care teams. *Personnel Review*. 45 (6) pp. 1132-1155.
- McLaughlin, H. (2009) What's in a Name: 'Client', 'Patient', 'Customer', 'Consumer', 'Expert by Experience', 'Service User'—What's Next? *The British Journal of Social Work*. 39 (6) pp. 1101-1117.
- McLeod, B. and Mair, M. (2009) *Evaluation of City of Edinburgh council home care re-ablement service*. Scotland. Scottish Government Social Research.

Meyer, T., Gutenbrunner, C., Bickenbach, J., Cieza, A., Melvin, J. and Stucki, G. (2011) Towards a conceptual description of rehabilitation as a health strategy. *Journal of Rehabilitation Medicine*. 43 (9) pp. 765-769.

Mickan, S. and Rodger, S. (2000) Characteristics of effective teams: a literature review. *Australian Health Review*. 23 (3) pp. 201-208.

Mickan, S. M. and Rodger, S. A. (2005) Effective Health Care Teams: A model of six characteristics developed from shared perceptions. *Journal of Interprofessional Care*. 19 (4) pp. 358-370.

Mikolaizak, A. S., Lord, S. R., Tiedemann, A., Simpson, P., Caplan, G. A., Bendall, J., Howard, K., Webster, L., Payne, N., Hamilton, S., Lo, J., Ramsay, E., O'Rourke, S., Roylance, L. and Close, J. C. (2016) A multidisciplinary intervention to prevent subsequent falls and health service use following fall-related paramedic care: a randomised controlled trial. *Age and Ageing*. 46 (2) pp. 200-207.

Mitchell, R. and Unsworth, C. A. (2005) Clinical Reasoning during Community Health Home Visits: Expert and Novice Differences. *British Journal of Occupational Therapy*. 68 (5) pp. 215-223.

Moe, A., Ingstad, K. and Brataas, H. V. (2017) Patient influence in home-based reablement for older persons: qualitative research. *BMC Health Services Research*. 17 (1) pp. 1-10.

Moore, G. F., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., Moore, L., O'Cathain, A., Tinati, T., Wight, D. and Baird, J. (2015) Process evaluation of complex interventions: Medical Research Council guidance. *British Medical Journal*. 350 pp. h1258.

Morse, J. M. (2015) Critical Analysis of Strategies for Determining Rigor in Qualitative Inquiry. *Qualitative Health Research*. 25 (9) pp. 1212-1222.

Nancarrow, S. (2004) Dynamic role boundaries in intermediate care services. *Journal of Interprofessional Care*. 18 (2) pp. 141-151.

Nancarrow, S. A., Shuttleworth, P., Tongue, A. and Brown, L. (2005) Support workers in intermediate care. *Health & Social Care in the Community*. 13 (4) pp. 338-344.

National Assistance Act 1948 (11 & 12 Geo. 6, Ch.29).

Neuman, W. L. (2014) *Social Research Methods: Qualitative and Quantitative Approaches*. Harlow: Pearson Education Limited.

Newbrunner, E., Baxter, M., Chamberlain, R., Maddison, J., Arksey, H. and Glendenning, C. (2007) *Research into the Longer Term Effects/Impacts of Re-ablement Services*. Care Services Improvement Partnership. Care Services Efficiency Delivery Programme.

Newbrunner, L. and Chamberlain, R. (2008). Improving independence- can homecare re-ablement make a difference in the long term? *Community Care* [online]. 19.06.08 Available from: <http://www.communitycare.co.uk/2008/06/19/improving-independence-can-homecare-re-ablement-make-a-difference-in-the-long-term/> [Accessed 28 October 2012].

Norris, R. (2008) A reabling approach. *Commissioning News, Issue 10, Dec/Jan 2008*, pp.8-9.

Nørskov Bødker, M. (2018) Potentiality made workable – exploring logics of care in reablement for older people. *Ageing and Society* [online] 25 April 2018 pp. 1-24. Available from: <https://www.cambridge.org/core/journals/ageing-and-society/article/potentiality-made-workable-exploring-logics-of-care-in-reablement-for-older-people/EDD3194C5C8F4DB7BFB272B8931B09F1> [Accessed 6 July 2018]

Nosowska, G. (2010) "Are Occupational Therapists ready to Put People First?". *Journal of Integrated Care*. 18 (4) pp. 43-48.

O'Campo, P., Kirst, M., Tsamis, C., Chambers, C. and Ahmad, F. (2011) Implementing successful intimate partner violence screening programs in health care settings: Evidence generated from a realist-informed systematic review. *Social Science & Medicine*. 72 (6) pp. 855-866.

O'Dwyer, L. M. and Bernauer, J. A. (2014) *Quantitative research for the qualitative researcher*. Los Angeles: SAGE.

Office For Public Management (2010) *Reablement: a guide for frontline staff*. North East Improvement and Efficiency Partnership.

Ogden, J. (2018) Where next for social prescribing in England? *Prescriber*. 29 (5) pp. 31-34.

Oxford University Press (2017) *English Oxford Living Dictionaries*. Available from: <https://en.oxforddictionaries.com/definition/occupation> [Accessed 8 July 2017].

Oxford University Press (2018) *English Oxford Living Dictionaries*. Available from: <https://en.oxforddictionaries.com/definition/patient> [Accessed 27 July 2018].

Parker, D. M. (2012) *An Exploration of Client-Centred Practice in Occupational Therapy: Perspectives and Impact*. Doctor of Philosophy, University of Birmingham.

Parsons, T. (1939) The Professions and Social Structure. *Social Forces*. 17 (4) pp. 457-467.

Pawson, R. (2006a) Digging for Nuggets: How 'Bad' Research Can Yield 'Good' Evidence. *International Journal of Social Research Methodology*. 9 (2) pp. 127-142.

Pawson, R. (2006b) *Evidence-based Policy A Realist Perspective*. London: Sage Publications Ltd.

Pawson, R. (2013) *The Science of Evaluation. A Realist Manifesto*. London: Sage Publications Ltd.

Pawson, R. (2015) The ersatz realism of critical realism: A reply to Porter. *Evaluation*. 22 (1) pp. 49-57.

Pawson, R. (2016) Realist evaluation caricatured: a reply to Porter. *Nursing Philosophy*. 17 (2) pp. 132-139.

Pawson, R., Greenhalgh, T., Harvey, G. and Walshe, K. (2005) Realist review - a new method of systematic review designed for complex policy interventions. *Journal of Health Services Research and Policy*. 10 (Supplement 1) pp. 21-34.

Pawson, R. and Manzano-Santaella, A. (2012) A realist diagnostic workshop. *Evaluation*. 8 (2) pp. 76-91.

Pawson, R. and Tilley, N. (1997) *Realistic Evaluation*. London: Sage Publications Ltd.

Pearson, M., Hunt, H., Cooper, C., Shepperd, S., Pawson, R. and Anderson, R. (2013) *Intermediate care: a realist review and conceptual framework. Final report*. NIHR Service Delivery and Organisation programme.

Pentland, D., Kantartzis, S., Clausen, M. G. and Witemyre, K. (2018) *Occupational therapy and complexity: defining and describing practice*. London: Royal College of Occupational Therapists

Petch, A. (2008) Reablement and the role of the occupational therapist. *Journal of Integrated Care*. 16 (2) pp. 38-39.

Petterson, C. and Iwarsson, S. (2017) Evidence-based interventions involving occupational therapists are needed in re-ablement for older community-living people: A systematic review. *British Journal of Occupational Therapy*. 80 (5) pp. 273-285.

Pilkington, G. (2013) *Homecare Re-ablement CSSR Scheme Directory Update August 2013*. Gerlad Pilkington Associates.

Plsek, P. E. and Greenhalgh, T. (2001) The challenge of complexity in health care. *British Medical Journal* [online]. 2001;323:625 Available from: <https://www.bmj.com/content/323/7313/625> [Accessed 21 July 2018]

Polatajko, H., Davis, J. A. and McEwen, S. E. (2015) Chapter 6 Therapeutic Use of Self A Catalyst in the Client-Therapist Alliance for Change. In: Christiansen, C. H., Baum, C. M. & Bass, J. D. (ed.) *Occupational Therapy Performance, Participation, and Well-Being*. 4th edition. New Jersey: SLACK Incorporated.

Polgar, S. and Thomas, S. A. (2000) *Introduction to Research in the Health Sciences*. Edinburgh: Churchill Livingstone.

Polley, M., Bertolli, M., Kimberlee, R., Pilkington, K. and Refsum, C. (2017) *A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications*. Available from: <https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network> [Accessed 21 July 2018].

Poor Law 1601 (43 Eliz. I, Ch.2)

Pope, C., Mays, N. and Popay, J. (2007) *Synthesizing Qualitative and Quantitative Health Evidence: A guide to methods*. Maidenhead: Open University Press.

Porter, S. (2015a) Realist evaluation: an immanent critique. *Nursing Philosophy*. 16 (4) pp. 239-251.

Porter, S. (2015b) The uncritical realism of realist evaluation. *Evaluation*. 21 (1) pp. 65-82.

Punton, M., Vogel, I. and Lloyd, R. (2016) *Reflections from a Realist Evaluation in Progress: Scaling Ladders and Stitching Theory*. CDI Practice Paper 18. Available from: <http://www.ids.ac.uk/publication/reflections-from-a-realist-evaluation-in-progress-scaling-ladders-and-stitching-theory> [Accessed 2nd June 2017].

QSR International Pty Ltd. (2012) NVivo qualitative data analysis Software, Version 10

Rabiee, P. and Glendinning, C. (2011) Organisation and delivery of home care re-ablement: what makes a difference? *Health & Social Care in the Community*. 19 (5) pp. 495-503.

Rabiee, P., Glendinning, C., Arksey, H., Baxter, K., Jones, K. C., Forder, J. E. and Curtis, L. A. (2009) *Investigating the Longer Term Impact of Home Care Re-ablement Services: The organisation and content of homecare re-ablement services: Interim Report*. Great Britain. Department of Health. Care Services Efficiency Delivery.

Rankin, J. and Regan, S. (2004) Meeting complex needs in social care. *Housing, Care and Support*. 7 (3) pp. 4-8.

Rees, E., Bourne, S. and Whittington, A. (1973) Letters to the Editor. *Occupational Therapy* 36 (12) pp. 574-576.

Reilly, M. (1962) Occupational therapy can be one of the greatest ideas of 20th century medicine. 1961 Eleanor Clarke Slagle Lecture. *American Journal of Occupational Therapy*. 16 (1) pp. 1-9.

Richards, H. and Emslie, C. (2000) The 'doctor' or the 'girl from the University'? Considering the influence of professional roles on qualitative interviewing. *Family practice*. 17 (1) pp. 71-75.

Richards, S. E. (1992) Community occupational therapy: past dreams and new visions. *British Journal of Occupational Therapy*. 55 (7) pp. 257-259.

Riley, J., Vincent, C. and Whitcombe, S. (2008) *Occupational therapy in adult social care in England: sustaining a high quality workforce for the future*. Available from: <http://www.dh.gov.uk/publications> [Accessed 22 October 2017].

Rosengard, A., Laing, I., Ridley, J. and Hunter, S. (2007) *A Literature Review on Multiple and Complex Needs*. Edinburgh: Scottish Executive Social Research.

Royal College of Occupational Therapists (2017) *Professional standards for occupational therapy practice*. London: Royal College of Occupational Therapists.

Royal College of Occupational Therapists (2018) *Embracing risk; enabling choice. Guidance for occupational therapists*. London: Royal College of Occupational Therapists.

Rubery, J., Grimshaw, D. and Hebson, G. (2013) Exploring the limits to Local Authority social care commissioning: competing pressures, variable practices, and unresponsive providers. *Public Administration*. 91 (2) pp. 419-437.

Rubin, H. J. and Rubin, I. S. (2005) *Qualitative Interviewing: The Art of Hearing Data*. Thousand Oaks, CA: Sage Publications.

Russell, C., Fitzgerald, M. H., Williamson, P., Manor, D. and Whybrow, S. (2002) Independence as a Practice Issue in Occupational Therapy: The Safety Clause. *American Journal of Occupational Therapy*. 56 (4) pp. 369-379.

Sackley, C. M., Burton, C. R., Mant, J., Wheatley, K., Stant, K. E. and Wilde, K. (2015) An occupational therapy intervention for residents with stroke related disabilities in UK care homes (OTCH): cluster randomised controlled trial. *British Medical Journal* [online]. 350:h468. Available from: <https://www.bmj.com/content/350/bmj.h468> [Accessed 2 September 2017]

Sainty, M., Lambkin, C. and Maile, L. (2009) 'I feel so much safer': unravelling community equipment outcomes. *British Journal of Occupational Therapy*. 72 (11) pp. 499-506.

Sakellariou, D. and Pollard, N. (2009) Chapter 6: Political challenges of holism: heteroglossia and the (im)possibility of holism. In: Pollard, N., Sakellariou, D. & Kronenberg, F. (ed.) *A Political Practice of Occupational Therapy*. Edinburgh: Churchill Livingstone.

Salter, K. L. and Kothari, A. (2014) Using realist evaluation to open the black box of knowledge translation: a state-of-the-art review. *Implementation Science*. 9 (1) pp. 115.

Schell, B. A. and Cervero, R. M. (1993) Clinical Reasoning in Occupational Therapy: An Integrative Review. *American Journal of Occupational Therapy*. 47 (7) pp. 605-610.

Schwandt, T. A. (1998) Chapter 7 Constructivist, Interpretivist Approaches to Human Inquiry. In: Denzin, N. K. & Lincoln, Y. S. (ed.) *The Landscape of Qualitative Research: Theories and Issues*. Thousand Oaks: Sage Publications.

Scourfield, P. (2006) 'What matters is what works?' How discourses of modernization have both silenced and limited debate on domiciliary care for older people. *Critical Social Policy*. 25 (1) pp. 5-30.

Seale, J. and Barnard, S. (1998) *Therapy Research: processes and practicalities*. Oxford: Butterworth-Heinemann.

Silver Chain (2007) *Silver Chain's Home Independence Program (HIP). User Manual*. Perth: Silver Chain.

Sinclair, I., Gibbs, I. and Hicks, L. (2000) *The Management and Effectiveness of the Home Care Services*. York: University of York Social Work Research and Development Unit.

Skelton, J. (2013) Why occupational therapists are central to reablement services. *The Guardian*. 25 October 2013

Social Care Institute For Excellence (2010) *Reablement: emerging practice messages*. Social Care Institute for Excellence.

Social Care Institute For Excellence (2011a) *Prevention: Reablement*. Social Care Institute for Excellence.

Social Care Institute For Excellence (2011b) *Reablement: a key role for occupational therapists*. Social Care Institute for Excellence.

Social Care Institute for Excellence (2012) *Personalisation: a rough guide*. London: Social Care Institute for Excellence.

Solman, B. and Clouston, T. (2016) Occupational therapy and the therapeutic use of self. *British Journal of Occupational Therapy*. 79 (8) pp. 514-516.

Spalding, N. J. and Phillips, T. (2007) Exploring the Use of Vignettes: From Validity to Trustworthiness. *Qualitative Health Research*. 17 (7) pp. 954-962.

Stake, R. E. (1995) *The art of case study research*. London: Sage Publications.

Stark, S. L., Somerville, E., Keglovits, M., Smason, A. and Bigham, K. (2015) Clinical Reasoning Guideline for Home Modification Interventions. *American Journal of Occupational Therapy*. 69 (2) pp. 1-8.

Stewart, A. (1994) Empowerment and enablement: occupational therapy 2001. *British Journal of Occupational Therapy*. 57 (7) pp. 248-254.

Strong, S. (2015) An Initiative to Improve Patient Discharge Satisfaction. *Rehabilitation Nursing*. 40 (1) pp. 52-59.

Sumsion, T. (1999) *Client-Centred Practice in Occupational Therapy: A Guide to Implementation*. Edinburgh: Churchill Livingstone.

Sumsion, T. (2000) A revised occupational therapy definition of client-centred practice. *British Journal of Occupational Therapy*. 63 (7) pp. 304-309.

Taylor, M. C. (2001) Independence and Empowerment: Evidence from the Student Perspective. *British Journal of Occupational Therapy*. 64 (5) pp. 245-252.

Taylor, R. R. (2008) *The Intentional Relationship: Occupational Therapy and Use of Self*. Philadelphia: FA Davis Company.

The Housing Grants, Construction and Regeneration Act 1996 (1996). London: The Stationery Office Ltd.

The National Health Service Act 1946 (9 & 10 Geo. 6, Ch.81)

Thew, M., Bell, F. and Flanagan, E. (2017) Social prescribing: An emerging area for occupational therapy. *British Journal of Occupational Therapy*. 80 (9) pp. 523-524.

Tinetti, M. E., Baker, D., Gallo, W. T., Nanda, A., Charpentier, P. and O'Leary, J. (2002) Evaluation of restorative care vs usual care for older adults receiving an acute episode of home care. *JAMA: The Journal Of The American Medical Association*. 287 (16) pp. 2098-2105.

Tinetti, M. E., Williams, T. F. and Mayewski, R. (1986) Fall Risk Index for elderly patients based on number of chronic disabilities. *American Journal of Medicine*. 80 (3) pp. 429-434.

Tomlin, G. and Borgetto, B. (2011) Research Pyramid: A New Evidence-Based Practice Model for Occupational Therapy. *American Journal of Occupational Therapy*. 65 (2) pp. 189-196.

Tuntland, H., Aaslund, M. K., Espehaug, B., Førland, O. and Kjekens, I. (2015) Reablement in community-dwelling older adults: a randomised controlled trial. *BMC Geriatrics*. 15 (145).

Unsworth, C. A. (2001) The Clinical Reasoning of Novice and Expert Occupational Therapists. *Scandinavian Journal of Occupational Therapy*. 8 (4) pp. 163-173.

Unsworth, C. A. (2004) Clinical Reasoning: How do Pragmatic Reasoning, Worldview and Client-Centredness Fit?. *British Journal of Occupational Therapy*. 67 (1) pp. 10-19.

Vik, K. and Eide, A. H. (2014) Evaluation of participation in occupations of older adults receiving home-based services. *British Journal of Occupational Therapy*. 77 (3) pp. 139-146.

Vogt, W. P. (2011) *SAGE quantitative research methods*. Los Angeles: SAGE.

Wallis, M. A. (1987) 'Profession' and 'Professionalism' and the Emerging Profession of Occupational Therapy: Part 1. *British Journal of Occupational Therapy*. 50 (8) pp. 264-265.

Walshe, C. and Luker, K. A. (2010) District nurses' role in palliative care provision: A realist review. *International Journal of Nursing Studies*. 47 pp. 1167-1183.

Waterlow, J. (1985) A risk assessment card. *Nursing Times*. 81 (49) pp. 51-55.

West, M. A. and Markiewkz, L. (2006) *The Effective Partnership Working Inventory, working paper*. Birmingham: Aston Business School.

Whitehead, P. J., Walker, M. F., Parry, R. H., Latif, Z., McGeorge, I. D. and Drummond, A. E. R. (2016) Occupational Therapy in HomeCare Re-ablement Services (OTHERS): results of a feasibility randomised controlled trial. *BMJ Open* [online] 6 DOI: [10.1136/bmjopen-2016-011868](https://doi.org/10.1136/bmjopen-2016-011868) [Accessed 2 September 2017]

Wilcock, A. A. (2001) *Occupation for Health Volume 1 A journey from self health to prescription*. London: College of Occupational Therapists.

Wilcock, A. A. (2002) *Occupation for Health Volume 2: A journey from prescription to self health*. London: College of Occupational Therapists.

Wilde, A. and Glendinning, C. (2012) 'If they're helping me then how can I be independent?' The perceptions and experience of users of home-care re-ablement services. *Health and Social Care in the Community*. 20 (6) pp. 583-590.

Winkel, A., Landberg, H. and Ejlersen Waehrens, E. (2015) Reablement in a community setting. *Disability and Rehabilitation* 37 (15) pp. 1347-1352.

Wolstenholme, E., Monk, D., McKelvie, D. and Arnold, S. (2007) Coping but not coping in health and social care: masking the reality of running organisations beyond safe design capacity. *System Dynamics Review*. 23 (4) pp. 371-389.

Wong, G., Greenhalgh, T. and Pawson, R. (2010) Internet-based medical education: a realist review of what works, for whom and in what circumstance. *BMC Medical Education*. 10 (12) pp. 1-10.

Wong, G., Greenhalgh, T., Westhorp, G., Buckingham, J. and Pawson, R. (2013) RAMESES publication standards: realist syntheses. *BMC Medicine*. 11 (1) pp. 21.

Wong, G., Greenhalgh, T., Westthorp, G. and Pawson, R. (2014) *Quality Standards for Realist Synthesis (for researchers and peer-reviewers)*. Available from: http://ramesesproject.org/media/RS_qual_standards_researchers.pdf. [Accessed 1 May 2018]

Wong, G., Westthorp, G., Pawson, R. and Greenhalgh, T. (2013) *Realist Synthesis. RAMESES training materials*. Available from: http://ramesesproject.org/media/Realist_reviews_training_materials.pdf [Accessed 1st May 2018].

World Federation of Occupational Therapists (2013) *Definitions of Occupational Therapy*. Australia: World Federation of Occupational Therapists.

World Federation of Occupational Therapists (2017) *Definitions of Occupational Therapy from Member Organisations*. Available from: <http://www.wfot.org/ResourceCentre.aspx> [Accessed 17 September 2017].

World Health Organization (2001) *International Classification of Functioning, Disability and Health*. Geneva: World Health Organization.

World Health Organization and World Bank (2011) *World report on disability*. Geneva: World Health Organisation.

Yin, R. K. (2009) *Case study research: design and methods*. London: SAGE Publications.

Zaheer, A., McEvily, B. and Perrone, V. (1998) Does Trust Matter? Exploring the Effects of Interorganizational and Interpersonal Trust on Performance. *Organizational Science*. 9 (2) pp. 141-159.

Appendices

Appendix A - Email to social services network of the Royal College of Occupational Therapists

Hi All

I met a number of you this time last year when we were working on the Future Focus of OT in Social Care paper. You may remember me telling you a little bit about my PhD study on Occupational Therapists in Reablement services. I hope you don't mind me using this distribution list to ask you for your help.

My PhD research is looking at the role and impact of occupational therapists working in reablement services in social care. I would be grateful for your help in the following areas:

1. Please can you advise whether you have a reablement service in your Local Authority and whether occupational therapists are included in the team for that service? Also, can you advise whether the service is 'in house' (ie a department of the Local Authority) or whether you have outsourced that service to another provider or social enterprise.
2. For my review of the literature I am completing a realist synthesis review looking at a broad range of evidence related to reablement services and particularly occupational therapists working in reablement services. I am concentrating on the theories and practice of what works (or doesn't work), in what circumstances; if you have any internal reports or audits of your reablement services that you would be happy to share, I would love to include them in my review.
3. I am also specifically interested in Local Authorities who have occupational therapists working in reablement services outsourced to other agencies. My research will involve interviewing and observing occupational therapists, managers and reablers/carers in three different Local Authority areas. I have identified one Local Authorities as a case study for my research. I am looking

for two more authorities who have outsourced their reablement service. I would be grateful if you would get in touch if your Council fit into this category and might be interested in being in my study.

Many Thanks

Lisa

[work address and telephone numbers supplied]

Appendix B Databases searched in literature review

- CINAHL – Cumulative Index to Nursing and Allied Health Literature
- AMED – Allied and Complementary Medicine
- Cochrane Library
- Embase
- Medline
- Social Policy and Practice
- Applied Social Sciences Index and Abstracts (ASSIA)
- British Humanities Index
- British Nursing Index International
- International Bibliography of the Social Sciences (IBSS),
- Social Services Abstracts
- Sociological Abstracts
- Worldwide Political Science Abstracts
- Social Care Online

Appendix C Example database search strategy

Database: Cinahl

Database host: EBSCO

Data Parameters: 1937 to week 12 2014

Search terms:

1. Reablement.ab
2. Re-ablement.ab
3. Enablement.ab
4. Restorative services.ab
5. Restorative care.ab
6. Rehabilitation.ab
7. 1 OR 1 OR 3 OR 4 OF 5 OF 6
8. Social care.ab.ti
9. Social services.ab.ti
10. Adult care.ab.ti
11. Local Authority.ab.ti
12. Community services.ab.ti
13. Home care.ab.ti
14. 8 OR 9 OR 10 OR 11 OR 12 or 13
15. Child*
16. student education
17. "Learning disabilities"
18. "learning disabled"
19. "mental health"
20. psych*
21. occupational therap*
22. 7 AND 14
23. 22 NOT 15 NOT 16 NOT 17 NOT 18 NOT 19 NOT 20
24. 23 AND 21

Appendix D Hits obtained from each database

Database	hits
CINAHL – Cumulative Index to Nursing and Allied Health Literature	177
AMED – Allied and Complementary Medicine	92
Cochrane Library	10
Embase, Medline and Social Policy and Practice	1441
Proquest databases: <ul style="list-style-type: none"> • Applied Social Sciences Index and Abstracts (ASSIA) • British Humanities Index • British Nursing Index International • International Bibliography of the Social Sciences (IBSS), • Social Services Abstracts • Sociological Abstracts • Worldwide Political Science Abstracts 	49
Social Care Online	880
TOTAL	2649
End note and manual de-duplication	-352
Unique records	2297

Appendix E – Appraisal form

Reference		Paper or electronic copy
Reason for reading (source)		
On initial lit search		
Date read	Article Type	
General Notes on usefulness		
Date of research	Location of research	
Intervention under study (I)		
Outcome (intended and unintended) (O)		
Contextual Factors (social, institutional, financial etc) (C)		
Mechanisms identified or potential (M)		
Programme theory (the underlying assumptions on how it is supposed to work)		

Study Type and Objective	
Measures	Results
Quality Appraisal	
Relevance	Rigour
Contribution the Study makes	
Promising Strategies (what was good, what works, when and why?)	
Anything else	

Appendix F Search terms used in second literature search

Equipment and social services (all terms as described previously)

600

training AND “occupational therap*” AND home care OR support workers OR carers OR “therapy assistants” AND community OR “own home”

57

goals OR outcomes OR assessment AND “occupational therap*” AND community OR “own home” 878

Total number of articles found in search 1535.

1433 articles were excluded at the screening stage using the following terms from the exclusion criteria previously described

- Child*
- student education
- “Learning disabilities”
- “learning disabled”
- “mental health”
- psych*

102 full text articles were screened for relevance and those included are listed in Appendix G

Appendix G Table of use of articles

Articles in **bold** type represent articles in the initial literature search used to formulate the four programme theories. Articles in *italic* were identified to support the programme theories. The table demonstrates how each article was used to identify or support programme theories, represented by a Y in the appropriate column.

Author(s) (date) [country]	Type of Study	Contributed to...				
		Programme theory identification	Programme theory 1 Recognition of skills	Programme theory 2 Holistic Practice	Programme theory 3 Provision of equipment	Programme theory 4 Working with support workers
<i>Armstrong (2001) [UK]</i>	Pilot study of the development of an assessment for occupational therapists in social care			Y		
Baker et al (2001) [USA]	Retrospective matched design evaluation of a restorative service.	Y				Y
<i>Barnes and Frock (2003) [USA]</i>	Report on training of support workers authored by senior occupational therapists					Y
<i>Bell (2001) [UK]</i>	Article proposing a strategy for the training of support workers					Y
<i>Boniface, Mason, Macintyre et al. (2013) [UK]</i>	Review of literature of occupational therapy practice in social care				Y	
Calderdale et al (2010)[UK]	Report on best practice in reablement	Y	Y	Y	Y	Y
Care Services Efficiency	Questionnaire to Local Authorities regarding reablement	Y	Y	Y	Y	

Delivery (2007) [UK]						
<i>Chamberlain et al. (2001) [UK]</i>	Audit of equipment provision in social care				Y	
Chinouya and Cook (2012) [UK]	Qualitative research on support workers in reablement services	Y				Y
College of Occupational Therapists (2010) [UK]	Statement by professional body for occupational therapists	Y	Y	Y		Y
<i>Creek, 2005 [UK]</i>	Opinion article discussing occupational therapy as a complex intervention		Y			
<i>Finlay (2001) [UK]</i>	Phenomenological study of holism and occupational therapy practice			Y		
Glendinning, Jones, Baxter et al (2010) [UK]	Mixed Methods, multi centre, study of reablement services compared to standard home care services (CSED study)	Y		Y	Y	
<i>Glendinning and Newbrunner (2008) [UK]</i>	Review of two studies of reablement					Y
<i>Hagedorn (1995) [UK]</i>	Text book on occupational therapy theory			Y		
Harris (2010) [UK]	Mixed methods evaluation of reablement pilot	Y	Y			Y
<i>Hocking, Murphy and Read (2011) [NZ]</i>	Qualitative study of older people and participation in daily occupations				Y	
Jones, Baxter et al (2009) [UK]	Mixed Methods, multi centre, study of reablement services compared to standard home care services	Y			Y	

Kent et al (2000) [UK]	Evaluation of reablement pilot	Y	Y			
<i>King, Parsons et al (2012) [NZ]</i>	Cluster randomised controlled trial of restorative care service		Y			
Latif (2011) [UK]	Mixed methods study on occupational therapists in reablement	Y			Y	Y
Le Mesurier and Cumella (1999) [UK]	Evaluation of reablement service	Y	Y			Y
<i>Lewin and Vandermeulen, 2010) [NZ]</i>	Non randomised controlled trial of the Home independence Programme (HIP)		Y			
<i>Lewin, Calver, McCormack et al (2008) [NZ]</i>	User manual for the Home Independence Programme (HIP)		Y			
<i>Lewin, De San Miguel, Knuiman et al, 2013) [NZ]</i>	Randomised controlled trial of restorative care programme (HIP)		Y			
Littlechild, Bowl and Matka (2010) [UK]	Mixed methods evaluation of a short term service promoting independence at home.	Y	Y		Y	
McLeod and Mair (2009) [UK]	Mixed methods evaluation of new reablement service.	Y	Y	Y	Y	Y
<i>Nancarrow (2004) [UK]</i>	Qualitative study of two case studies of intermediate care services		Y			
<i>Nancarrow, Shuttleworth et al (2005) [UK]</i>	Quantitative evaluation of a development programme for support workers					Y
<i>Newbronner, Baxter et al (2007) [UK]</i>	Report on longer term effects of reablement (CSED study)			Y		Y

Norris (2008) [UK]	Evaluation of reablement pilot	Y				
<i>Nosowska (2010)</i> [UK]	Report on personalisation conference		Y			
Petch (2008) [UK]	Opinion of social care research organisation	Y	Y			
Rabiee, Glendinning, Arksey et al., 2009 [UK]	Mixed Methods, multi centre, study of reablement services compared to standard home care services (CSED study)	Y	Y		Y	Y
<i>Rabiee and Glendinning (2011)</i> [UK]	Report on the organisation and delivery of reablement (CSED study)				Y	Y
<i>Rankin and Regan (2004)</i> [UK]	Article on a model of managing complex needs		Y			
Riley, Whitcombe et al. (2008) [UK]	Mixed methods study of occupational therapists in social care	Y	Y	Y		
<i>Rosengard, Laining et al (2007)</i> [UK]	Literature Review of Multiple and Complex Needs		Y			
<i>Sainty, Lambkin and Maile (2009)</i> [UK]	Postal survey to adults who had received equipment from occupational therapists.				Y	
<i>Skelton (2013)</i> [UK]	Opinion piece by Director from Royal College of Occupational Therapists on occupational therapists in reablement					Y
Social Care Institute for Excellence (2011) [UK]	Briefing by social care improvement support agency	Y	Y	Y		Y
<i>Stewart (1994)</i> [UK]	Professorial lecture		Y			

<i>Tinetti, Baker, Gallo et al (2002) [USA]</i>	Retrospective matched design evaluation of a restorative service.					Y
<i>Wilde and Glendinning (2012) [UK]</i>	Qualitative study of service users' experience of reablement (part of the CSED study)		Y		Y	

Appendix H Social Care Research Ethic Committee Decision Letter



Social Care REC
An NRES Research Ethics Committee

11 November 2013

Mrs Lisa C J Dibsall



Dear Mrs Dibsall

Study title:	A critical exploration of the role and impact of occupational therapists working in reablement services in adult social care.
REC reference:	13/IEC08/0042
IRAS project ID:	134840
Ethical opinion:	Favourable (with conditions)

The Social Care Research Ethics Committee reviewed the above application at the meeting held on 01 November 2013. We would like to thank you for attending the meeting to discuss the application.

After the Committee's initial deliberations on the application, you joined the meeting and clarified the following issues:

- 1. The Committee asked you to explain where the idea for the study came from.** You explained that you are currently undertaking a part-time PhD as well as working as an OT. The justification for the research is that there has been no primary research to date which focuses on the role of OTs in reablement services, especially those outsourced to independent providers via local authorities.

The Committee commented that they thought there was quite a body of published work in this area and asked you for details of your literature search. You stated that you had done a literature search on a number of databases and had found a number of studies but none entirely relevant to the area you are looking at.
- 2. Further information was requested by the Committee about the orientation of the study content and methodology.** The methodology had changed from a comparative study to a multiple case study approach, you stated, because due to the number of changes in services, a comparative study between services was no longer possible.
- 3. In response to a question from the Committee about an ethics review from the University of the West of England, you confirmed that a review had been undertaken in 2012 and that the biggest issue had been that people were not coerced into taking part. The Committee requested a copy of the review be forwarded to them.**

206 Marylebone Road, London, NW1 6AQ
Tel 0207 535 0900 Fax 020 7535 0901 www.scie.org.uk
SCIE is a charity registered in England and Wales Reg. No. 1092778 Company Reg. No.

4. **The Committee noted that the views of services users were not being included, the study was only looking at OTs and asked you to clarify this approach and to justify the necessity to observe one or two OTs in each case study area as they did not see the added value to this approach.**
You clarified that the observations were for you to establish what was happening in practice. You want to study the interactions between people.

You had considered seeking the views of service users but this is a new service for which service users are continually being asked their views and you did not want to add to this burden.
5. **The Committee commented that the draft interview schedules do not seem to reflect the research objective. The questions, especially for support workers and managers are heavily weighted towards their specific roles as opposed to how they perceive the role of the OT.**
6. **You were asked if you will show service users and OTs your notes to see if they are accurate.**
You responded that you had not considered this in depth but did think you should check the accuracy of the notes with them. The Committee stated that they would like you to reflect on how this could be achieved and consider the role of the service users as they are part of the process.
7. **The Committee requested clarification on the adult protection policies and procedures you will be following.**
You confirmed that each local authority you will be working in has adult protection policies which you will be following. The Committee requested a copy of the University of West of England 'Safety of Social Researchers' policy mentioned in the application and asked if your husband being the contact point for you, complies with this policy. You responded that your husband would not know any details, just where you are, as you are a part-time student at the University.
8. **The Committee noted that you intend to keep data at home in a locked cabinet and on a home PC and reminded you that identifiable data must not be kept at home.**
9. **The Committee informed you that there are a number of issues with the documentation, details of which would be forwarded to you. One being a missing breaching confidentiality statement on the participants information sheets (PISs).**

After you left the meeting, the Committee considered your responses.

The members of the Committee present gave a **favourable ethical opinion** of the above research on the basis described in the application form, protocol and supporting

documentation, subject to the following conditions being met prior to the start of the study.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

- a. Review the draft interview schedules to ensure they reflect the research objectives.
- b. Reflect on how service users and OTs can review your notes to ensure accuracy.
- c. Consider the role of the service users as they are part of the process.
- d. Personal identifiable data must not be kept at home.
- e. The following issues were identified on the participant information sheets (PISs) and the appropriate changes should be made:
 - The consent forms seek consent for use of direct quotes but this is not stated in any of the PISs.
 - Therapist begins with a capital 'T' at times on the PIS for service users. Consistency is required.
 - The section on 'Possible benefits of the research' needs to be included on the PIS for service users.
 - Reflect on how you express yourself and the tone of communication in the PIS for service users. The title is too long and assumptive. Ensure that participation by service users is non-coercive. The title needs to be revisited as well as the content in this section of the PIS for service users. The correct tone is set in the other PISs by stating 'This leaflet explains why the research is being done and what it would involve for you. This level of expression is missing in the PIS for service users.
 - Your role for the service user is confusing. On the one hand you say that you are observing the OT and on the other you state 'if you agree to being observed, I will ask you to sign a consent form'. A 30-1 of the IRAS form states that the PIS and consent form will be given to the service user by the OT and you will provide a stamped addressed envelope. This is contradictory to the statement 'I will ask you to sign a consent form'.
 - The PIS for OTs suggest 'the information I get from the study will help to inform a theory of how...' This section should be revisited so that it is more consistent with the research outcomes.
 - There is no breaching confidentiality statement on any of the PISs. The Committee recommend: *'Everything you say/report is confidential unless you tell us something that indicates that you or someone else is at risk of harm. We would discuss this with you before telling anyone else'*.
 - Review by the Social Care REC is not mentioned in the PISs although review by the University is.
 - Question A46 of the IRAS form states that support workers will be given travel expenses but this is not mentioned in the relevant PIS.

- On the PIS for Service Users: under the heading "What is the purpose of this study?" the word 'reablement is used repeatedly as if repetition alone will make the meaning clear. We suggest that "enable them ...' is changed to 'teach them' or even 'help them to learn ...'
- The heading 'Why has my Occupational Therapist been chosen and what will they be asked to do...?' is very confusing. If it is 'my Occupational Therapist', it should be "... what will I be asked to do ...?"
 -
- f. The following issues were identified on the consent forms and the appropriate changes should be made:
- The Committee generally recommend the use of multiple rows of yes/no tick boxes for each statement so that is clear what participants are agreeing to.
 - Presumably the phone number and address for OT, support worker and manager will be an agency address and not a personal address. Therefore why is consent required?
 - There is a need to revisit the phrase '...address and any difficulties I have...' on the consent form for service users.
 - The service user consent form needs to make clear that withdrawing participation at any point will not affect the service they receive.
 - Why do you need an address on the consent form for service users?
- g. Forward a copy of the University of the West of England's ethics review.
- h. Forward a copy of the University of West of England 'Safety of Social Researchers' policy.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Guidance on Research Governance approval is available from the Department of Health supported Research Governance Framework: Resource Pack for Social Care (2nd ed, April 2010) London, which can be found at:

<http://www.researchregister.org.uk/files/RGFGuidancepack2010.pdf>

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Evidence of insurance or indemnity		15 July 2013
Evidence of insurance or indemnity		11 July 2013
Interview Schedules/Topic Guides	1	29 August 2013
Investigator CV		30 September 2013
Letter from Sponsor		31 October 2013
Other: Supervisor CV - Dr Stuart McClean	1	01 August 2013
Other: Supervisor CV - Dr A Turton	1	01 August 2013
Participant Consent Form: Service User	2	29 August 2013
Participant Consent Form: Occupational Therapist	2	29 August 2013
Participant Consent Form: Support Worker	2	29 August 2013
Participant Consent Form: Manager	2	29 August 2013
Participant Information Sheet: Service User	2	29 August 2013
Participant Information Sheet: Occupational Therapist	2	29 August 2013
Participant Information Sheet: Support Worker	2	29 August 2013
Participant Information Sheet: Manager	2	29 August 2013
Protocol	2	30 August 2013
REC application	134840/5149 89/27/754	17 October 2013

Membership of the Committee

The members of the Social Care Research Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the Social Care REC website – www.screc.org.uk and look at the 'After Ethical Review Section' for details of further requirements.

The attached document 'After Ethical Review – Guidance for Sponsors and Investigators' gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

Feedback to the Social Care REC

The Committee would welcome your views on the service you have received from the Social Care REC and the application procedure. You can do this anonymously by completing our feedback form at: www.screc.org.uk/feedback.asp

13/IEC08/0042

Please quote this number on all correspondence
--

HRA/NRES are pleased to welcome researchers and R & D staff at their NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



Professor David Stanley
Chair

Barbara Cuddon
Social Care Research Ethics Committee Co-ordinator
Direct Line: 020 7024 7660
Barbara.Cuddon@scie.org.uk

Social Care REC Website: www.screc.org.uk

*Enclosure: List of names and professions of members who were present at the meeting and those who submitted written comments.
'After Ethical Review – Guidance for Sponsors and Investigators'*

Copy to: Mrs Leigh Taylor, Research Administrator, UWE, RBI, Research Administration, Room 3E035, Frenchay Campus, Coldharbour Lane, Frenchay, Bristol, BS16 1QY

Social Care REC

Attendance at Committee meeting on 01 November 2013

Name	Profession	Present
Professor David Stanley - Chair	Independent	Yes
Sandra Andrews	Police Officer	No
Jeanne Carlin	Carer	No
Samantha Clemens	Social Researcher	Yes
Professor Malcolm Cowburn – Alternate Vice Chair	Professor of Applied Social Science at Sheffield Hallam University	No
Professor David Croisdale-Appleby	Wolfson Research Inst. & Chair, Skills for Care	Yes
Suki Desai	Independent Academic	Yes
Rachel Dittrich	Research Manager	No
Dr Michael Dunn	Senior Researcher in Health and Social Care Ethics	Yes
Susan Harrison – Vice Chair	Consultant and Interim Manager in Adult Social Services	Yes
Claire Hopkins	Independent	No
Claire Lambert	Social Researcher	Yes
Valerie Lang	Retired	Yes
Irene Linder	Retired	Yes
Craig Moss	Research Manager	Yes
Bridget Penhale	Reader in Mental Health of Older People	Yes
Dr Kathylene F Siska	Social Worker/Academic	Yes

Also in attendance:

Name	Position (or reason for attending)
Barbara Cuddon	Social Care REC Co-ordinator

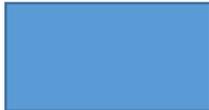
Appendix I Social Care Research Ethics Committee Approval Letter



Social Care REC An NRES Research Ethics Committee

24 January 2014

Mrs Lisa C J Dibsdall
102 Manor Gardens



Dear Mrs Dibsdall

Study title: A critical exploration of the role and impact of occupational therapists working in reablement services in adult social care.
REC reference: 13/IEC08/0042
IRAS project ID: 134840

Thank you for your letter of 23 January 2014. I can confirm the Social Care REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 11 November 2013

Documents received

The documents received were as follows:

Document	Version	Date
Covering Letter		23 January 2014
Interview Schedules/Topic Guides	2	
Other: Letter from University of West of England Ethics Committee		02 November 2012
Other: University of West of England - the Safety of Social Researchers		01 April 2006
Participant Consent Form: Service Users	3	17 January 2014
Participant Consent Form: Occupational Therapists	3	17 January 2014
Participant Consent Form: Support Workers	3	17 January 2014
Participant Consent Form: Managers	3	17 January 2014
Participant Information Sheet: Service Users	3	17 January 2014
Participant Information Sheet: Occupational Therapists	3	17 January 2014
Participant Information Sheet: Support Workers	3	17 January 2014
Participant Information Sheet: Managers	3	17 January 2014

Fifth Floor, 2-4 Cockspur Street, London SW1Y 5BH
tel 020 7024 7650 fax 020 7024 7651 www.scie.org.uk

SCIE is a charity registered in England and Wales Reg. No. 1092778 Company Reg. No. 4289790

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	Version	Date
Covering Letter		23 January 2014
Evidence of insurance or indemnity		15 July 2013
Evidence of insurance or indemnity		11 July 2013
Interview Schedules/Topic Guides	2	
Investigator CV		30 September 2013
Letter from Sponsor		31 October 2013
Other: Supervisor CV - Dr Stuart McClean	1	01 August 2013
Other: Supervisor CV - Dr A Turton	1	01 August 2013
Other: Letter from University of West of England Ethics Committee		02 November 2012
Other: University of West of England - the Safety of Social Researchers		01 April 2006
Participant Consent Form: Service Users	3	17 January 2014
Participant Consent Form: Occupational Therapists	3	17 January 2014
Participant Consent Form: Support Workers	3	17 January 2014
Participant Consent Form: Managers	3	17 January 2014
Participant Information Sheet: Service Users	3	17 January 2014
Participant Information Sheet: Occupational Therapists	3	17 January 2014
Participant Information Sheet: Support Workers	3	17 January 2014
Participant Information Sheet: Managers	3	17 January 2014
Protocol	2	30 August 2013
REC application	134840/5149 69/27/754	17 October 2013

13/IEC08/0042

Please quote this number on all correspondence

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

Yours sincerely



Barbara Cuddon
Social Care Research Ethics Committee Co-ordinator
Direct Line: 020 7024 7660
Barbara.Cuddon@scie.org.uk

Social Care REC Website: www.screc.org.uk

Copy to: *Mrs Leigh Taylor, Research Administrator, UWE, RBI, Research Administration, Room 3E035, Frenchay Campus, Coldharbour Lane, Frenchay, Bristol, BS16 1QY*

Appendix J Interview schedules

Interview Schedule Occupational Therapists

1. How long have you been an occupational therapist?
2. How long have you worked in the reablement service at [name of organisation]? What other occupational therapy roles have you held prior to your current post?
3. What are the keys areas of your role? What do you spend most of your time doing?
4. What do other staff refer to you for?
5. When I visited you you were setting up a telecare item for a customer, how does telecare and other equipment fit into your role? What do you use it for? Are there factors that affect whether it is used or accepted by service users?
6. What knowledge and skills do you think are needed in this role?
7. What training have you received in this role?
8. Can you tell me about goal setting with service users? (prompts: how to customers manage goal setting? Are there factors that influence how patients engage with their goals?)
9. You have support workers both with [name of organisation] and with [name of independent organisation]. I have seen some support workers in the office, do all support workers come in? What contact do you have with the support workers (prompt re informal/formal supervision)
10. Can you tell me about their training in reablement. Are occupational therapists involved in training the support workers? (follow up questions: Do you think OTs should be involved? In what areas?)
11. I wanted to talk about reviewing patients, so each service user has a coordinator who would regularly review them? Twice weekly you review the service users on the boards as a team? Can you tell me more about that?
12. Can you give me an example of your work with a patient that went well? (reasons for this)

13. What do you think are the main factors that help occupational therapists be effective in their role in the reablement team
14. Are there any factors that hinder you in your role? (prompt re equipment, following up from previous conversation during observations)
15. What do you think is the most important aspect of your role? Do you think occupational therapists have a unique role in reablement? What is that role?

Managers interview schedule – employers of occupational therapists

1. What is your role in the reablement service? How long have you been in this role?
2. Can you tell me about the development of the reablement service?
3. What is the role of occupational therapists in the team?
4. What skills and experience would you look for in employing occupational therapists to be in the reablement team?
5. Are there any factors that impact on reablement being a short term service?
6. I understand that there have been some changes to the service since it started, how are staff involved in changes to the service?
7. I wanted to talk about support workers. I have observed a number of the occupational therapists in practice working with support workers. How do you see the relationship between occupational therapists and support workers?
8. The reablement service has support workers in your organisation and in [name of independent organisation], can you tell me how that came about?
9. How do the two organisations work together? (what helps, what hinders, communication)
10. Are your occupational therapists involved in the training or induction of support workers? In what way?
11. Working across health and social care involves working with different legislation, how do you ensure occupational therapists keep up to date with current legislation, such as the implementation of the Care Act? Has the Care Act had an influence on the reablement service?
12. What do you think is the most important contribution occupational therapists make in the reablement service
13. Are there any factors that hinder occupational therapists carrying out their role?
14. Are there any areas in which you would like to see the occupational therapy role develop in the reablement? What would help make that happen?

Managers interview schedule - independent organisations

1. What is your role in providing this reablement service? How long have you been in this role?
2. I only know a little about [name of their organisation] from speaking to occupational therapists in the reablement service. Can you tell me how [name of service] fit into the reablement service?
3. Can you tell me about the development of the reablement service?
4. Can you tell me what happens when you receive a referral? (the process)
5. Do you set goals/outcomes with the service users?
6. My research is about occupational therapists working in reablement services how do the occupational therapists work with your organisation?
7. Can you describe a scenario or situation when you would ask for an assessment or support from an occupational therapist?
8. What do you see as the role of the support workers?
9. What kind of training programme do you have for your support workers?
10. How do the two organisations work together? (what helps, what hinders, communication)
11. Are there any factors that hinder you having access to occupational therapists ?
12. What is the most important contribution that occupational therapists make in for your organisation?

Appendix K Support worker focus group schedule/topics

Introduction

I'm a PhD student looking at the role of occupational therapists in reablement services in different organisations. I am an occupational therapist. I do not work for [name of reablement service] and I do not work in reablement. In my research I observe therapists, interview them and interview other people in the team (mostly managers). I also holds group with support workers to hear your perspective about working with occupational therapists. How occupational therapists influence your role.

Ground rules –

There are no right or wrong answers, only differing points of view . Be respectful you may not always agree with each other. The focus group is being recorded and I will transcribe it so if we could talk one at a time that is really helpful.

1. For the purposes of the recording please could everyone say their name and how long have you been in the reablement role?
2. Has anyone worked as a paid carer or support worker not in reablement? How is the role the same or different?
3. Tell me about your role in reablement . What kind of tasks do you get involved in? (role the same from hospital and community?)
4. Can you tell me about any equipment you use with service users? (prompts: do you demonstrate equipment? Can you provide equipment or recommend it?)
5. I understand that the worker from [name of reablement service] sets goals for the service user, occupational therapists have described themselves as client centred assessing people's difficulties and focussing on the priorities of the service user. would you agree with this statement?
6. You work on the service users goals with them,do you feed back progress to occupational therapists?
7. Do you ever visit the [name of Local Authority element of reablement service] teams? Do they visit your team?

8. If you had to explain to a service user/client what occupational therapists do, what would you say?

9. Can anyone tell me an experience of working with a service user and an occupational therapist that went really well?

10. Think back to when you started, what contact did you have with occupational therapists? (training?), what about ongoing?

11. Occupational therapists have described themselves as problem solvers. Have you seen this in your work with occupational therapists?

12. If you were the manager and could make one change with regard to your work with occupational therapists what would you do?

Appendix L Excerpts from interviews and observation notes

Excerpt from Interview with occupational therapist in Averdale

So then, in terms of the support, you get supervision? And what about...you are co-located with physios and the district nurses are just there, how is that? Does that help or...?

Yeah, it does actually. I quite like being...you say co-located with district nurses. It's reassuring if you've got a question about a service user medically that it might not necessarily need....you don't need to speak to the doctor it's just a query you have about how they condition is normally managed. What is normal for them? What involvement they are having? And if they're not there they have message books and they usually get back to you within the day if you've not actually seen them face to face. And yes, I have done joint visits with district nurses as well which has been really useful. Not as a focussed day or anything but the odd service user where, say they've needed two people to help move them and there's something I want to do with them and also the district nurse would use it as an opportunity to check their pressure areas and use of the hoist. So I've gone and done double up visits with them in those situations.

Do double up visits with the same service user rather than shadowing of her role as it were?

Yes

When we visited someone the other day you were setting up telecare for them, how do you think that telecare and other equipment fit into your role?

I think that we like the idea of it but quite often it doesn't quite fit the mould. There's been a few occasions where I've wanted a piece of equipment to work and it hasn't quite and I've had to go for a simpler option.

Ok

I don't know why I've homed straight in on the negative. That's because of my experience this week.

What is the example about?

Well this week the person that I was setting the telecare up for they have financial concerns they weren't really expressing in the beginning and we've realised that actually the person could do with some other form of external prompt. It could just be an alarm on a phone. So we're gonna go down that route first just to see if that's enough for them because they are able to read. So they would be able to read text on the phone. Because they are able to read the text on their exercises. So they don't need the spoken word that the telecare provides. So we're going to back track on that one.

So for them, that was about finance, because it was an ongoing cost?

Yes, that's a kind of...that's with telecare specifically. I find that if I have an idea that I'd like someone to try as soon as they hear that it costs something I then have to revert to thinking of simpler options again when in an ideal world the telecare would be great for them.

Whereas ordinarily equipment wouldn't cost to the person would it?

No, not the equipment that we have within the equipment stores. The stock items we just issue them when we identify a need for them. So that includes bathing equipment like bath boards, bath steps, raised toilet seats, commodes. Bath lifts even as well. If we say...if the person meets the criteria to have one we can issue bath lifts as well, which is quite good. And then equipment for beds, different types of rails, hospital beds we can get issued as well, mattresses, overlays, different types of pressure cushions. There's quite a lot actually. If there's an item that's not in stores then we have to request it specially and then that has to have funding agreed. So that's the only thing but I think the store are actually pretty well equipped

...

And how do service users cope with goal setting, do they understand the concept of that or...?

I think they understand if we explain it right. It's hard...it's really hard to put it in a box and quantify it if you just thinking somebody generally needs to be safer when they're transferring. But I try and say to them in their...in real terms what it means for them. So 'I want you to be able to get up out of your chair safely'. But then actually they won't realise that's their goal unless you say 'I'm going to write this down as a goal for your therapy. I know it sounds simple but really to break it down that's what we're hoping that our input will help you achieve. So it's a goal'. Yeah, it's a funny concept to grasp. It's not like going to the gym and saying 'I want to be able to run half an hour in under....you know say five miles in half an hour or something. It's a bit hard to quantify it with people.

And do people...do you ever have conflict with maybe, family members or somewhere else, in terms of what they think the person should be...the service they might get from reablement?

Yeah, I haven't personally but I know that there have been issues in the past with complex service users expecting that we can do a lot more for them and enable them to do a lot more that actually they physically end up being able to do. Or they...maybe we reach a point where the team needs to discharge or refer onto another service, say neurology team. They're not quite ready for us to move them on and we have to justify why they're no longer suitable for our service. It's....sometimes it goes back to actually remembering that we're meant to be short term and I find that as long as that is explained in the beginning and the

family members know what the purpose is, that helps a lot. That helps the process a lot and they work with you much more collaboratively.

Because they understand the expectations or...?

Yeah, exactly. They're not just letting you carry on and just, kind of, thinking that you are going to fix everything.

So they need to be involved?

Yeah, exactly. You're collaborating with...it helps if you do collaborate with the family as well, of the service user, yeah.

Excerpt from notes of observations of an occupational therapist in Tollbury

Attendance at feedback meeting at [name of independent organisation]

Present –Occupational therapist (Clare, pseudonym) , Senior practitioner at hospital (social worker), assistant social worker (from Local Authority team supporting people following reablement), 11 support workers, independent organisation manager.

Meeting started with a quick run through of cases being seen by reablement. Actions included referring to other health led community rehab teams.

Frequent feedback comment 'no change'.

Snr prac queried whether Clare would have given information re funding own care and following it up. Asst care mgr offered to follow up, Clare said they would follow up – *cross over in roles or lack of definition of roles?*

Feedback largely involved discussing personal care. Support workers suggested a bed and rail for someone, following discussion of details Clare will visit. – *suggestions were listened to, Clare to make final decision*

Some discussion in detail related to outcomes eg 'he wanted to make a salad'. Some support workers said 'he uses bottles and jars eg beetroot and pickles'. Clare asked support workers for their opinion saying 'can we change anything?', Some support workers said 'no', others said he had chopped lettuce and cucumber. The assistant social worker suggested options – *perhaps due to inconsistency of responses Clare agreed to visit again*

Asst social workers, independent organisation manager and Clare asked similar questions on progress to the support workers.

Most of the 11 support workers in the meeting fed back information. The spoke up if they'd seen the service user, most service users had been seen by a few

support workers. The support workers often had differing opinions of service users and talked over one another.

There were some disagreements on the abilities of the person for example one support worker said that they couldn't put their jumper whilst another said that had down that whilst she had visited.

Support workers provide specific feedback requested by Clare for example Clare said '[name of support worker] said showering is difficult, is it the transfer in and out or showering?'. The support workers confirmed that the transfer was OK but the service user has COPD and becomes breathless.

Different options were discussed in the meeting such as medication dispensers and telecare prompts and practice was checked. For example support workers said a service user was able to use the bath. Clare checked that the service user was using correct technique, eg when using bathboard to get in the bath.

The meeting was a place for banter, honest comments eg saying they felt uncomfortable seeing one service user who they described as 'creepy'.

Focus of the assistant social worker was on closing cases.

Home Visit observing Clare

Female – husband and daughter also present. Service user discharged from hospital.

Clare – clearly introduced herself. Clarified current situation including getting in and out of bed independently as hospital assessment said that she couldn't manage this.

Clare explained that reablement was a short term services. Clare introduced the concept of goals but without saying the word 'goals' said 'what would you like to be able to do?'

Evidence of observation skills – Clare watched service user use stairlift with verbal prompts from daughter then returned to this topic to clarify 'I noticed your daughter helped you to use the stairlift'....'we're all about you learning to do things for yourself again'.

She repeated that they are a short term service for up to six weeks. They talked about different options to meet needs if blister pack for medication wasn't successful.

Clare asked about daily routine. Conversation included issues outside of reablement 'do you want me to telephone the continence service?' (and confirmed consent). Clare returned to talking about daily routine and service user returned to talk about continence. Clare asked re washing and dressing 'can you wash your personal areas?', service user 'yes', 'are you able to get dressed?', 'yes'.

Daughter interjected with facts and called the support workers nurses – Clare didn't correct daughter.

'would you like to be able to make a cup of tea?'. Service user: 'I don't always need a cup of tea, Yes, I would like to be independent'. Husband said 'she can't make a cup of tea'. Service user: 'No, I don't want to be able to make a cup of tea'.

Daughter's concept of independence : husband makes the microwave meals.

Daughter: 'I won't let her use the cooker now. I like them to use the microwave'

Husband: 'yes, use the microwave'

Clare explained that the purpose of her visit was to set goals [*she spoke in a person centred way*] eg 'my job is to set goals. If you are happy with what is happening with meals then we won't set a goal for that.

Clare asked direct questions on communication, eyesight and hearing. Clare checked support workers' case notes. She paraphrased notes saying 'I've noticed the support workers are helping with dressing and undressing and changing pads. Could you change your pads yourself?' 'what about setting those things as goals, to get dressed and undressed yourself?'

Clare checked details with daughter who had a lot input during the visit.

Observed service user mobilise around the home including bed and commode transfers and toilet transfers. Clare talked about routine.

Clare gave verbal prompts for example stairlift was new. Service user asked 'do I press here?' Clare: 'try it and see if it works'.

Clare offered to refer service user to locality occupational therapist re assessment of bathroom with a view to provision of level access shower. Family said they would fund this themselves. Clare recommended level access rather than a low access shower.

Clare stated that she had to do some admin. She gave out leaflets and explained what they were. Wrote goals, then explained them to the service user saying 'I want everyone to agree'.

Appendix M Examples of data analysis

Extract from manual initial analysis of interview with manager of independent organisation

Code: questions in **bold**, responses in normal black text, initial analysis in *red italic* text.

So it started with an initial pilot didn't it so that was a lot smaller. Then they have dedicated people to do the initial visit but now it's got larger that hasn't occurred.

And also what you would find at the initial visit is that they have one agenda and we have a different one. So we would kind of cross wires with what we were trying to achieve. So if they've already assessed them and discussed what is going to happen, at the hospital or in the community, the initial visit is for us to explain and for us to meet them and introduce them to the service and to discuss what we are going to be doing on the visits specifically. So actually they could be a hindrance with regards to.. we have our paperwork that we need to fill out.

Manager asserts that local authority staff and agency have different agendas. Agency need to fill in their risk assessment paperwork to meet CQC expectations and they want to introduce service user to the company and the service. Considered LA staff as a hindrance. Manager sees the goals and plan that is written by original assessor as good enough for them then to work with the service user on.

So your risk assessment and your things that need to be done.

Yes so in a lot of cases it could be quite simple and straightforward and they could actually be more of a hindrance to our time constraints with what we're trying to do.

Because for you, you already have the goals. It is your opportunity to discuss with the service user/client how you are going to work with them to meet those goals. So it is about that kind of communication between you and the client. Whereas if the OT was there their part, in a way, was done in terms of that assessment and writing the goals?

Yes. There's very little need for them to actually be there in most cases because they've already been working with them and they've written the plans.

So what kind of case would you want them there? If things were a bit more complex or...?

Potentially if it's quite complex but they usually say... If it's a double up with equipment they usually send a handling plan anyway. So to be fair...

So you'd get their written stuff there and the equipment would be there.

Yes so there's no real need for them to be at the initial visit really.

And when I met the occupational therapists they were quite confident that actually if they put on the plan they wanted the reablement workers to work with perhaps grading a task or something like that. They were confident that the reablement workers could do that. Do they have training in those kind of things or do the OTs work with them on a one-to-one basis with people or...?

No our staff are trained from obviously induction through shadowing and they all communicate amongst themselves as well because you'll have in any team different skill sets and different experiences.

Training involves sessions on induction, shadowing and communication/learning from each other. Is this a technical approach that affects their reasoning? Additional input from OT not seen as required even if new equipment to the worker 'it's very rare that we have equipment that nobody has worked with'. Another example of workers learning from each other, rather than thinking about use of the equipment for an individual person. Focus is on information in the support plan.

So with shadowing they wouldn't necessarily need any additional input from occupational therapists.

No

When I see occupational therapists in reablement they've described themselves as problem solvers, have you seen that in practice, would you agree with that?

Yes definitely.

In terms of working out how to do things or...?

Yes, obviously the staff are very experienced but they're not occupational therapists. So if they're coming up against something that they're not really sure how to go about it then they would discuss it with somebody like an OT.

Manager sees a difference between just experience and recognition of OT knowledge and skills. 'obviously the staff are very experienced but they're not occupational therapists'. Manager asserts that workers would go to OTs if they were unsure of what to do.

Extract from NVivo report of references to code: goal setting

<Internals\\Case Study 1\\CSI-OTI-INV-F> - § 6 references coded [7.63% Coverage]

Reference 1 - 4.48% Coverage

You mentioned there about goal setting. So you would set the goals if they were in the community if they come from hospital then [name of agency] set the goals?

No, we still set the goals. We set the goals for all of them. The ones in the community we set the goals sort of on the first visit that we go out and sort of set up the package and everything. The hospital ones, obviously we don't go out until a few days later. But on our first visit we would then set the goals on that one. Um.. so they almost miss out on a few days before goals are set. But then, you know, coming out of hospital is so stressful that they kind of need a few days to settle and get into a routine of having carers come in, all of that, before you are then rushing in and say 'right ok, let's set some goals, what are we going to do. Like today for instance. If I would have tried to set goals today. So many people in and out it was so manic it just wasn't the right situation because she only came home a day or two ago. So we set them a little bit later.

And do you always find that people are accepting of setting goals?

Yes and no. most people yes they are quite happy and. You know, obviously your goals are set with them. So it's not me saying 'right this is what we're going to do and you've got no say in it, kind of, you know. 'so let's have a chat about what we're gonna...what you'd like to achieve...what's, kind of, realistic. But we do get some people, kind of, like 'well what am I signing up to..or 'what is this?' But generally if you explain what it is then they are kind of Ok. We've probably had very few cases that come out...it would be a hospital one..that come out and say 'well I never asked for reablement. I don't want reablement. I just want care. I don't want to do this etc etc. So for them you can't set goals because they don't want to..to get better or anything. They just want people coming in and doing for themselves.

Reference 2 - 0.34% Coverage

a washing and dressing assessment at the very beginning. That would give you a better idea of, kind of, setting more specific broken down goals.

Reference 3 - 0.32% Coverage

I guess our main role is... Goal setting and sort of planning intervention things and reviewing people I guess it's the OT process isn't it.

Reference 4 - 0.30% Coverage

so I think the main role really is looking at the goals and you know, doing the functional assessment with people is the main thing.

Reference 5 - 0.74% Coverage

What makes it go well is when you've got a customer who's motivating and engaging. Someone who wants to regain their independence you've got support workers who are actually encouraging and let them get on with doing things rather than doing it for them you are setting goals that are achievable and are realistic really.

Reference 6 - 1.44% Coverage

sometimes it's not a case of we've made them independent and they don't need anything anymore it's actually have we increased their independence? So on all of my goals I never say 'to be independent with washing and dressing I will always say to increase independence with washing and dressing because I'm not going to promise that you'll be independent at the end of the six weeks but my aim is that you will have increased your independence in some way. It might be tiny. It might be big. So then it might be, you know, rather than 45 minutes in the morning they only need half an hour in the morning, sort of, ongoing.

<Internals\\Case Study 1\\CSI-OT1-OBS-F> - § 2 references coded [0.63% Coverage]

Reference 1 - 0.32% Coverage

OT wrote down goal 'to enable Mrs G to wash and dress'.

Reference 2 - 0.31% Coverage

Goals form – doesn't lend itself to writing SMART goals.

<Internals\\Case Study 1\\CSI-OT2-INV-F> - § 2 references coded [7.88% Coverage]

Reference 1 - 6.03% Coverage

Yes I've done basic training on what an OT is and what an OT does and what our role in the service is and just introduced them to some of the basic equipment and

small aids and those types of things as well. Talked about goal setting I've done some training... It was in the same block of training for new starters only. So I talked to them about documentation and what we need to know and those types of things.

Did they know what an OT was before the training?

Some of them did. I'd say probably the majority of them did. But I think there was a general...I don't like to generalise because some of them had a really good knowledge of what OT did, but there was a general misconception that we order equipment only. I think the goal setting side of things was quite new to them.

Thinking about goal setting, what is important for you in setting goals for somebody?

I like to identify where we're going to end up but I also like to identify how we're going to get there which is why I introduced the intervention plan alongside the goal setting. That wasn't really in the service. I was trying to incorporate...my goals when I started were really, really long 'so and so will achieve independence in dressing through graded support from support workers, the use of a sock aid and an OT providing a perching stool [pause for laughter] within two weeks!'. You can't write all that out by hand in someone's house when they've got four goals. So I've kind of broken it down now. We have a basic overall goal 'they're gonna achieve independence with dressing and the timescale is generally within the period they're open to [name of reablement service]. So that's going to be less than a six week period and then now I've got the intervention plan to outline how we're going to achieve that goal

Reference 2 - 1.85% Coverage

So then you list each goal separately?

Yeah and then break it down. It depends some of the support workers are quite good at breaking things down anyway so I don't want to patronise people but I do want to simplify it so that if there are particular issues, that we are breaking things down into what we need achieved week by week. But also what needs to be done, and what the person has agreed to do. They might have agreed to buy a lightweight kettle. You know, the components that make up all the things that come together to achieve that goal.

<Internals\\Case Study 1\\CSI-OT2-OBS-F> - § 5 references coded [6.79% Coverage]

Reference 1 - 2.04% Coverage

Customer – been in [name of town] community Hospital. They get referrals direct from OT on the ward. OT provides MOTOM scores from the ward. For pilot – they still get assessment from hospital social worker. Social worker will have agreed goals based on OTs recommendation.

Reference 2 - 0.86% Coverage

Clare introduced the concept of goals but without saying the word ‘goals’ said ‘what would you like to be able to do?’

Reference 3 - 1.56% Coverage

Clare explained that the purpose of her visit was to set goals [*she spoke in a person centred way*] eg ‘my job is to set goals. If you are happy with what is happening with meals then we won’t set a goal for that.

Reference 4 - 1.72% Coverage

She paraphrased notes saying ‘I’ve noticed the carers are helping with dressing and undressing and changing pads. Could you change your pads yourself?’ ‘what about setting those things as goals, to get dressed and undressed yourself?’

Reference 5 - 0.61% Coverage

Wrote goals, then explained them to the customer saying ‘I want everyone to agree’.

<Internals\\Case Study 1\\CSI-OT3-INV-M> - § 4 references coded [11.73% Coverage]

Reference 1 - 6.45% Coverage

My next one is about goal setting obviously you set goals with people or set outcomes at the end of that assessment what do you think is important to you when you’re setting those goals?

I think it is important that the service user or customer wants to achieve those things, very much so. I will as we go through the assessment I will have in the back of my mind what they might need to do to achieve things or what they might need to achieve. So actually as we’re talking about it I’m almost priming them to what the goals might be. They own what they going to do if you like. When we are talking about washing and dressing I’ll say is that something you want to be able to do yourself again. How do you feel about somebody coming in to help you do things. When it comes to goal setting nothing I say on the goals

sheet in my mind should be a surprise to the person because we would have actually done that as part of the assessment of what they wanted to achieve through the regaining independence service. So why give them a good explanation of what we are and what we do and then will talk about the specific problems they have and how they want to overcome them and then what their goal is. What their destiny is with that particular problem. So when it comes to goal setting it's more of an affirmation of the whole assessment. It's almost like a little summary for them so I say okay we've said you want to do that is it okay if I write that down that my goal is within three weeks (I like to make them time measurable) that you will be able to wash your upper body and your lower legs. So try and make them specific as well. So that's more recent I'd say that I'm getting better at setting goals. I was never very good to start with because we just went in and said 'oh they need to wash and dress and needs help to do that. I think having MOTOM, sort of, makes you assess exactly where they are at and then having SMART goals gives you a time to measure them, to achieve what we're asking them to do by. So, we get them to write them down and own them and it's not necessarily always goals that [name of agency] or [name of reablement service] are going to be able to achieve with them. It may be longer term ones like by next year you might want to go out to a garden centre or something like that, you know. If it's something that is important to them you might resume gardening next year. So long term goals as well.

Reference 2 - 0.25% Coverage

And we put in place a programme of, you know, encouraging him to eat regularly, which he did.

Reference 3 - 1.62% Coverage

we want that person to own their goals to achieve what they want to achieve and we should be there to facilitate that and to work with them to achieve the goals they want to achieve. That's the way I would view it.

<Internals\\Case Study 1\\CSI-OT3-OBS-M> - § 3 references coded [6.56% Coverage]

Reference 1 - 0.96% Coverage

Client – alcoholism. Goal – to build a routine of eating 3 meals per day. Can set goals for each week. Also has a goal re washing and dressing.

Reference 2 - 4.23% Coverage

Goal setting – Pete ‘ultimately you want to be independent with showering’. ‘we use SMART goals...how long to do you think that would take?’, Customer - ‘two weeks’, Pete ‘that sounds realistic’ Pete explained that not setting end date but a goal.

Whilst customer was speaking with carer Pete wrote down two other goals - one about preparing meals within 2 weeks of having her sling off and the second one – to complete application and resume driving.

Discussed gardening – Mr felt she would need help with this and put that as a goal. Pete said ‘it’s just setting yourself some targets...something to aim for...we’re not going to hold to that’

Reference 3 - 1.37% Coverage

There is spreadsheet of goals updated weekly – this includes intervention plans for support workers. There is a use of set phrases to adapt for individual customers. The customer doesn’t see the spreadsheet.

<Internals\\Case Study 3 (S)\\CS3-MGR2-INV-F> - § 1 reference coded [3.73% Coverage]

Reference 1 - 3.73% Coverage

Do you set goals with the clients when you start care?

Yes. So the team leaders go through and they look at what the overall outcome the service user would like, the individual would like in reablement and then throughout they’ll try and set little mini...with people that, sort of, are more willing to work towards the mini goals to get to the big goal if you like. So they might set very short, each week have a review, set another goal. So it might be a very small thing like being able to clean my own teeth, which isn’t actually a small thing but in the grand scheme of things if someone isn’t able to do much for themselves that could be a massive thing for them.

<Internals\\Case Study 3 (S)\\CS3-OTI-INV-F> - § 6 references coded [11.71% Coverage]

Reference 2 - 2.03% Coverage

So the Monday meeting is to catch up with what’s happened over the weekend because we have less staff over the weekend and it’s to review everyone’s goals. So that’s discussing all of the service users which are on what’s called our urgent board which is people who are having input from both OT and physio or quite

intensive input from one or the other and having support workers visits, so care visits, because we have another caseload as well which is generally people you're only seeing one-off or you're waiting to review them it's not having intensive support. So Monday we look at where we are with that person what their goals are and how close we are to achieving them.

Reference 3 - 2.43% Coverage

You mentioned something about setting goals with the person. How do your service users take that goal setting? How do they, kind of, manage that?

I think it...generally most people are quite realistic. Sometimes that's the area where they need a bit of support, is to make it realistic. But they're usually...I usually term things as 'we're a short term service, when we've finished working with you at what level do you see yourself being?' and that generally works quite well. I think usually people see it in...a lot of people don't really want care so they see it...their goals are usually care related in that 'I want to be finishing without having any care' rather than specific to the task of 'I want to be able to independently shower', it will be more 'I want to be able to do my morning routine on my own'

Reference 4 - 2.59% Coverage

that are referred but maybe aren't motivated to do those goals or...?

Yeah, that is quite a hard one because we do get people who...and that's probably comes through more, rather than from the health pathway but come through more through the social care pathway. So you do have people who just want to have two visits a day and they want that from the beginning. They know that that's what they want and they haven't necessarily got the justification of why they need it. They just want it because they're x years old and they are entitled to it and you get those people who come through and they can be really difficult to set goals with and that's when you're having to be a little more facilitating them in setting those goals because they need to be a bit more realistic and that's when it's really important at the beginning to explain that we're short term.

Reference 5 - 0.71% Coverage

She was really motivated to be independent so goal setting was really easy with her because she knew exactly what she wanted and the main thing...the first goal she wanted to achieve was the night time. She didn't want to have to wait.

Reference 6 - 1.42% Coverage

We don't... generally OTs technique is not to go out and say 'you're going to do thing and you're going to do that and this is how you're going to do it'. We'll probably get the same outcome if not a better outcome but we approach it in a different way in letting that person have a lot more control over the way that they meet those outcomes. But I don't think that that could be...it's not very easily measured and it's not very easy to observe either. It's quite tricky

<Internals\\Case Study 3 (S)\\CS3-OT1-OBS-F> - § 3 references coded [5.89% Coverage]

Reference 1 - 1.44% Coverage

Customer was a case referred from another OT. Goals set in free text in the format: 'Mrs A would like to be able to get into her bedroom with greater ease'.

Reference 2 - 1.41% Coverage

Goals – issues 'some people see service as 6 weeks free care'. See it as an entitlement. Some customers need to work with them on setting realist goals.

<Internals\\Case Study 3 (S)\\CS3-OT2-INV-F> - § 5 references coded [7.31% Coverage]

Reference 1 - 0.46% Coverage

I always do a general assessment of need with a new person and then we try and set some initial goals early but I find that my goals tend to develop over the next couple of sessions with the person.

<Internals\\Case Study 3 (S)\\CS3-OT2-OBS-F> - § 1 reference coded [4.33% Coverage]

<Internals\\Case Study 3 (S)\\CS3-OT3-INV-F> - § 5 references coded [10.19% Coverage]

Reference 1 - 1.67% Coverage

Reference 2 - 2.47% Coverage

So...again it's trying to manage expectations and trying to say 'this is what we can help you with' without being too prescriptive and saying 'this is all we do'. You want to help them to achieve all their personal goals but you're just very aware that actually I know full well that the service won't be able to come in every single day for an hour in the morning and an hour in the afternoon to work towards a specific goal when this person is going to be there with this resource. Sometimes you know that perhaps you're not going to be able to support it; not because you don't want to but because the services aren't there to cover it.

Reference 4 - 2.11% Coverage

Yeah and being able to sit in a chair for five hours that's to a lot of people 'great what am I going to do with that'. So for them the tangible thing is to go on holiday isn't it? I think people that are cognitively absolutely fine then generally once you've talked to them about why you need to break it down like this and what each stage means and how each stage will implement on their life and quality of life, generally they can come around and understand where you're coming from. But I don't think people would be able to say 'well I want to be able to run a marathon so actually my goal is going to be able to walk from this room to this room'. People won't naturally break it down like that which is understandable. Like you said it's to see the big picture isn't it and the events that are important to them.

<Internals\\Case Study 3 (S)\\CS3-OT4-INV-F> - § 5 references coded [9.30% Coverage]

Reference 3 - 1.09% Coverage

And getting them to see what goals are more important to them as well; is it more important that they get washed themselves in the morning because some people are very private and independent and that's what they want to do, to heck with the rest of the day and for other people 'I really want to cook that dinner but by the time I've done everything in the morning I've just got no energy left and I can't'. So it's finding out what's important to that person and why and working in that way with them, I feel and also within the remit of the service

Reference 4 - 0.65% Coverage

I mean there's no point promising the moon if it's something we can't deliver. Some people do want it. Somebody described it the other day as wanting the moon on a stick with sparkles on. I think, yeah, some people do want the moon

on a stick with sparkles on and get very frustrated when we can only give them the moon. [laughter]

<Internals\\Case Study 3 (S)\\CS3-OT4-OBS-F> - § 1 reference coded [2.73% Coverage]

Reference 1 - 2.73% Coverage

Service user asked re carers. OT explained reablement's 'healthcare assistants' (the name the service user had called the hospital staff). OT explained they're support workers. 'the difference is they support you to return to independence. They won't let you struggle or be in pain but they are supporting you...we have a goal orientated service'. OT gave an example of a goal 'to walk steadily and independently with a frame'.

Appendix N Excerpt from excel spreadsheet of context mechanism outcome configurations

Config number	Theme	Intervention	Context	Mechanism	Mechanism fires/does not fire	Outcome
22	Assessment	Assessment with specific reference to service users with two carers (known as double handed care) I5	In two of the areas the reablement service had a specific remit to reduce double handed care to single carer visits where possible. This sat within the contexts of Local Authorities/organisations seeking to reduce care spend. C23	Use of assessment skills of occupational therapists M8	mechanism fires	Ongoing care packages reduced where possible to provide financial savings for the Local Authority. O22
23	Goal setting	Goal setting at the beginning of reablement I7	Occupational therapists worked with service users to set goals for the period of reablement, listening to service users and agreeing goals with them C24	person centred approach/collaborative working of occupational therapist M2 . Motivation of service user increased	mechanism fires	when the occupational therapist demonstrated a person centred approach goals set were meaningful to the service user. When the mechanism of the motivation of the service user fired, O23 service users were engaged
24	Goal setting	goal setting by other members of the reablement team I7	In one areas goals for reablement were set by the support worker side of the service and occupational therapists may set further goals with the service user C25	M19 Trust between organisations	does not fire	O24 Goal setting across agencies in the same service relies on trust. When trust was not present occupational therapists set goals alongside the goals written
25	Goal setting	Occupational therapists setting goals with service users I7	Occupational therapists used a number of different phrases to introduce goals C26	M20 - simplification. occupational therapists' skills in simplification and aiding	yes	O25 Using different language to introduce the concept of goals aiding understanding by the service users.
26	Goal setting	Occupational therapists setting goals with service users I7	Occupational therapists felt that breaking down goals was important. It was important to occupational therapists that goals were	M21 ?a theory on achieving goals. Occupational therapists being person centred and wanting service users to		O26 Having realistic and achievable goals was perceived as giving the service user the best chance to succeed.

