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Making sense of interprofessional reablement practice in different contexts

1 Introduction

Governments around the world are attempting to change their health care system in order to better meet the needs of an ageing population. The Norwegian government call for health and social care provision to be more proactive and preventative and to better utilize the interdisciplinary expertise of health care staff (Ministry of Health and Care Services, 2014). Hence, various forms of intermediate care solutions, including reablement, has popped up over the past decade.

Though the importance of breaking down silos has always been recognized, the idea of working across disciplinary boarders is more than ever seen as a panacea of ill organized health care systems. Interprofessional collaboration and related concept such as inter-agency, partnership and teamwork have become global buzzwords throughout the first part of the twenty-first century (Pullen-Sansfacon & Ward 2012). A key policy driver is the World Health Organizations' "Framework for Action on Interprofessional Education and Collaborative Practice" (WHO 2010) which calls for health and education systems to join forces in order to develop health workers into a collaborative practice-ready work force.

Phrases like 'interprofessional care' and 'interprofessional collaboration' seem to have the potentials for being seductive. They have the hallmarks of being 'magic concepts', characterized by a high degree of abstraction, a strongly positive normative charge, a seeming ability to dissolve previous dilemmas and a mobility across domains. For government facing both quality demands and increasing cost pressure, optimizing interprofessional practice may seem like an obvious solution. However, the idea may appear so appealing that underlying complexities may easily be overlooked. According to Paradis & Whitehead (2015) interprofessional education (IPE) literature, tend to underpin the seductive character of interprofessional practice. Reviewing more than two thousand articles, the authors conclude that there is a general lack of attention to issues concerning power and conflict. Hence, education programmes are expected to transform individuals into effective collaborators,

without heed to structural, organizational and institutional factors. The IPE literature has also been criticized for breing narrowly focused on conceptions and ideals of face-to-face teamwork, leaving out other forms based on relationships that are more diffuse. Reeves et al (2018) argue that, in order to contribute to more realistic form of interprofessional collaboration, notions of interprofessional team work should be expanded by drawing on a contingency approach i.e. an approach taking into consideration that the most appropriate style of interprofessional is dependent on the context of the situation.

Agreeing that interprofessional practices should be conceptualized in light of a real life context, I will push the argument one step further by assuming that interprofessional practices are always embedded, not only in organizational settings, but in a wider economic and socio-political context (Nancarrow & Borthwick 2005). Interprofessional practices are social constructions being result of an active process of sensemaking whereby actors are taking part in the creation, maintenance and transformation of organizational institutions (Czarniawska Sahlin & Wedlin). Drawing on data from a comparative case study in two Norwegian municipalities, this paper aim to explore how beliefs and practices related to interprofessional practices are framed by policy ideas implemented within different governance context. The study centers on reablement, a new international policy narrative which promotes intrinsic capacity and functional ability, as opposed to discourse around aging and dependency. Reablement is commonly understood as a short-term, home based intervention where care staff and therapists work in cooperation to enable the patient to regain capacity to maintain a meaningful and active life. By focusing on processes of social constructions and sense-making, the paper draw on a broad constructivist turn in social science. A basic claim of this approach is the rejection of the view that broad policy ideas have given, fixed or essential character. Hence, rather than seeking to answer "what interprofessional working in reablement *is* or *should be*", I find it fruitful ask what actors being involved in the implementation of reablement take interprofessional practice to mean in a particuar context. Why is interprofessional practice important? And how can this underlying purpose be realized within a given historical and social context? Before turning to these empirical questions, I will briefly describe some shifting trends of governance in Norwegian municipalities and the way in which different modes of governance operate with different conceptions and ideals of professionals.

2. The role of professionals in shifting modes of governance

In Norway, local authorities are given a free hand to govern and organize services in ways that accommodate local circumstances. Still, they have always been influenced by the views and recommendations of central authorities. Administrative reforms have been conceived as joint central-local projects with substantial elements of experiment, mutual learning and replication across municipal borders and boarders with neighboring Nordic countries.

The autonomous role of local authorities consolidated through a comprehensive set of decentralization reforms that came into effect during the mid-1980s and early 1990s. Local authorities were then assigned responsibility for statutory services such as primary health care and various kinds of housing and care services target towards older people in need of care. A core argument behind the decentralization reform was to make services adapted to local conditions and to provide services in close contact with people. Buzzwords of the late 1980s and early 1990s stressed awareness of local problems, flexibility, and proximity and user participation.

In this era home based care work was typically organized in self-regulated teams, whereby considerable decision making power was delegated to front-line staff – both registered nurses and semi-skilled nurses. The autonomy of care staff was justified on the ground that staff are dealing with contextual, complex and shifting needs (Vabø 2012). This way of organizing services, corresponds to the model categorized by Stephen Osborn (2010) as the Classical Public Administration (PA) model – a model in which the exercise of power is legitimized, based on democratically adopted rules and professional skills. However, in Norway, like elsewhere the trust in professionals gradually was questioned as output and organizational processes came under increasing scrutiny (Vabø 2012). Following Osborn (2010) this distrust-based control mentality may be seen as a consequence of a shift in governance towards a new generation of public administration, the New Public Management (NPM).

In Norway, soft versions of NPM became widespread. Public service providers were encouraged to "advertise" services through citizens charters and to modernize their service apparatus by splitting up responsibilities in line with a purchaser-provider model. The purchaser-provider model was regarded a structural precondition for municipalities who contracted out services. However, it was (more often) adopted on the ground that local authorities would be more apt to make quality demands and subsequently to control costs and manage quality at arm's length. The work of home care staff was increasingly controlled by various forms of performance measurements, used primarily for keeping costs down (Vabø

2012). Sometimes standards and citizen charters provided information not only about entitlements, but also about services that people not entitled to expect. Hence, service elements – were tacitly off-loaded from publicly funded home care (Vabø & Szebehely 2011).

A trend towards more task based and standardized way of providing care challenged the autonomy and legitimacy of care professionals. Whereas they within the previous care regime were seen as creative "enablers", continuously assessing needs and working to enable elderly people to promote their own self-care, they were now seen as responsible "doers" – providing care tasks based on predefined quality standards and assessments made by purchaser officials (Vabø, 2012).

In many municipalities NPM reforms certainly contributed to splitting up and curtailing care responsibilities. However, care staff often worked against the system; they cut corners and made adjustments in order to feel that they were doing something worthwhile (Vabø 2006). Moreover, a substantial number of (small) municipalities were regarded as "reform laggards" (Lægreid & Christensen) as they retained the PA model and continued to delegate power and responsibilities to front line staff.

Gradually unintended consequences of NPM, associated with phrases like time tyranny and 'stop-watch-care', have been recognized in public discourses. Since the 2005 election left wing parties has argued that NPM related accountability arrangements are costly and dysfunctional, as they draw attention away from essential care task and contribute to undermining care staff motivation. As a counter strategy these parties call for "trust reforms" aiming at dismantling bureaucratic control systems and building trust and motivation at the front line.

Parallel to a growing skepticism towards NPM, a global 'collaborative turn' has found its way to Norwegian municipalities. Inspired by a green paper "Innovation in the Care Services" (NOU 2011:11) the challenges of a an ageing population is currently understood as complex and cross-cutting – impossible to be managed by public sector organizations alone. Osborn (2010) has labelled this trend toward horizontal, collaborative governance New Public Governance (NPG), as it represent a break with both the previous PA and NPM models. NPG is launched as a common denominator for a number of initiatives aimed at achieving good welfare solutions across agencies and sectors (Koppenjan, 2012). Whereas NPM reforms typically were intra-organizational, relying on performance measure and sanctions based on competition between single service providers, NPG reforms are inter-organizational and rely on a variety of accountability procedures and multiple standards attuned to organizational

learning (Torfing & Triantafillou 2013). An implicit idea of NPG is that knowledge to solve problem is dispersed and as such interprofessional working seem to be a core element of the model. According to Brandsen & Honningh (2013: 881) this implies that objectives and standards of individual professionals is likely to be contested within complex and dynamic arenas. The new mode of governance may however also pave the way for new professional projects and thereby contribute to make profound changes in workplace settings (Suddaby & Viale 2011, Burau et al 2017).

3. A sense-making approach

A rapid spread and popularity of reablement services and other kind of interprofessional interventions in adult care, may indicate that horizontal modes of governance are gaining momentum in Norway. However, as noted by Newman (2001) and Termeer (2009) developing and implementing these horizontal strategies of governance is difficult.

Public managers may talk the talk of working across boundaries. Nevertheless, they tend to get entangled with all kinds of barriers rooted in more vertical modes of governance (Termeer 2009). Within constructivist institutional theories these challenges may be seen as a mismatch between new ideas and existing social contexts of other ideas, actors, traditions and institutions (Sahlin & Wedlin 2005).New conceptions of governance and organization of professional work will never enter a world of tabula rasa, but a social world already infused with meaning and its own vocabulary. They will always interact with norms and practices established under earlier administration, producing struggles between new and "old" ways of working (Newman 2001, Termeer 2009, Torfing et al 2016).

When organizational actors experience ambiguity and have to cope with issues that can no longer be understood within existing routines and schedules, an active process of sense making comes to the fore (Temeer 2013). This will typically happen when public managers face new policy challenges (like reablement).

A process of sense making can however never be a solitary act of managers (Weick 1995). Mangers will always have to fit their own line of activity with the actions of others. In interacting with each other, different actors negotiate on the meaning they give to the new forms of practices. As new roles and routines may be layered on top of existing practices, they tend to produce a field of tension whereby people struggle to fix the meaning of new concepts (Newman 2001).

These processes of interpretation and translation may take place in many different arenas and levels of an organisation (Czarniawska & Joerge 1996) and will be "filtered "through the heads of different actors and thus influenced by other ideas, traditions and institutions (see

also Sahlin & Wedlin 2008:219). Weber & Glynn (2006) underscore that institutions are the feedstock for sensemaking and not simply cognitive constraints suggesting that some things are taken-for-granted and other things unthinkable and un-sensible. A particular idea can be perceived by some actors as something that is a matter of course or something that is already known, but may , by other actors be regarded as new insight (an eureka moment) that changes a person's way of thinking and acting (Czarniawska & Joerge 1996).

4. The research study

In the context of the constructivist approach outlined above, this paper reports on an investigation into two Norwegian municipalities setting up a reablement service. A principle aim of the study was to explore how the rather loose ideas associated with reablement are translated into practice under different local context. In which ways are this new service innovation constrained or underpinned by structural arrangements and modes of thought associated with different models of governance (Osborn . A design aiming at comparison of similar initiatives between different context is often a preferred design in contextualize research (Pettigrew 1990). The assumption is that policy measures trigger change somewhat different in different context.

The two participating municipalities were selected on the ground that they had previously followed different trajectories in their efforts to improve the local governance structure. The first municipality, Southplace, belonged to the category of "NPM laggards", as it had largely retained a PA model. This implied that the responsibility for assessing and providing services was negotiated between line managers and professionals working at the operational level. Echoing the Official Norwegian Report Innovation in the Care Services (NOU 2011:11) Southplace was in a process of adopting ideas associated with NPG – stressing the need for building capacity within the public delivery system through various forms of co-production with citizens and local communities. The contrasting case-municipality, Northplace, had previously been inspired by NPM. Health and care services were organized in in accordance with a purchaser-provider model whereby the responsibility for assessing needs and allocate services had been separated from the responsibility of providing care. The purchaser unit had a particular responsibility for complying with legal prescriptions and keeping costs at a moderate level.

Data from the two municipalities were collected over a period of three years (2014 -2017). During this period, a range of different data was utilized, collected from various levels and arenas in the two municipalities: local policy documents, administrative data, three join meetings were held where key actors from both municipalities participated, interviews with key actors such as local senior managers, purchaser officers, front line managers and professionals directly involved in reablement. The research team also organized twelve group reflection sessions among care staff and made occasionally direct observations in meetings, local arrangements related to the daily work of care staff.

Over the three years, several notes and reports were written and revised, based on comments and discussions with a reablement project group from each of the two municipalities. Through these written accounts the common sense rationale behind strategies and decisions of the two municipalities were made explicit. .

A cross-case analysis was conducted, drawing on all of the above-mentioned data sources. In line with other local studies (Birkeland et al 2017; Hjelle et al 2016, 2018) previous research this analysis revealed that actors generally expressed positive attitudes towards working across disciplines. Nevertheless, it gradually became apparent that the enthusiasm were attributed to quite different forms of interprofessional practices. In the remaining of the paper I will demonstrate how the divergent governance context of the practices materialized differently as they were framed within the different governance contexts of the two municipalities.

5. Making sense of reablement within divergent governance contexts

As mentioned earlier, reablement is generally understood as an early intervention, time-limited service that takes place in the home and the local environment of service recipients. Unlike conventional home-care services, reablement aims to assist people to regain functional capacity and improve independence and quality of life by offering an intensive, multi-disciplinary, person-centred and goal-directed intervention. Reablement is endorsed to be more cost effective compared with conventional home care. Although an intensive and interprofessional intervention may be more costly pr hour, the higher price of reablement is likely to be offset by longer-term savings from reduced social care-related needs (see for instance Kjerstad & Tuntland 2016; Langland et al).

Managers and senior professionals who were in charge of implementing reablement in the two case- municipalities agreed that reablement was a 'smart' way of working. Their stories about *why* reablement was the self-evident way to improve their service apparatus were typically based on dual arguments, telling both about how peoples' life had improved after a short period of reablement and about the cost saving achieved as the short term intervention had removed the need for ongoing support via traditional home care.

Although actors in both municipalities talked about cost saving, it gradually became apparent that they had divergent beliefs about cost-effectiveness which linked to their overarching notions of governance. As will be further elaborated below, this implied that the concept of reablement was ovelayed with different meanings.

Southplace: Reablement as a spearhead in a joint effort to prevent and reduce long term care

In Southplace, setting up a reablement service was highly entangled with a more overarching process of change aiming at a more preventative and person centred health approach. The senior professional who became the leader of the reablement service was also representing Southplace in a policy network among municipalities who were trying out integrated generic care pathways – i.e. structured multi agency care plans that defines the essential steps and a seamless course of events for people discharged from hospitals.

Within the burau-professional regime of Southplace, it was regarded a matter of course that that managers and senior professionals from the operational level were key actor in the process of implementing reablement. The reablement project group was entrusted a large degree of freedom to design the new service at their own professional discretion. They were responsible for choosing an adequate organizational design, for developing procedures to recruit and select candidates deemed appropriate for reablement as well as procedures for specific needs assessment, interventions and follow-up routines. Following the vision of the local government to make service provision more preventative and proactive, they decided to organize the reablement service as an autonomous team. It was their core idea that the team would operate as a 'spearhead' of their health and care apparatus. The metaphor 'spearhead', underscored important features of the new reablement service in two ways. Firstly, they made it clear that the service was not supposed to be an exclusive service offer, operating separately, side by side with other services. Rather, the team should operate at the front of a

whole network of services. Secondly, reablement was supposed to be a "strong and sharp" part the service apparatus. As such they emphasized that a highly competent interprofessional team was supposed to develop new expertise in reablement.

Making sense of reablement in this way, the leader of the reablement team worked intensively to spread knowledge about the new service and to encourage professionals in other service units to consider whether they had candidates who could benefit from an intensive reablement intervention. She took it upon herself to visit the four home care service zones, the local in-patient rehabilitation and respite ward, a psychiatric service team, the region's central hospital and some of the GPs located in the municipalities. Written information about the service was provided in the waiting rooms of doctors, physiotherapists and other health care services, narratives about the positive impacts of the new service were published in the local newspaper.

The team leader encouraged professionals not to be hesitant about referring potential candidates. The motto of the reablement team was the following:

It is better to make too many referrals than too few. When it comes to people who are in the gray zone between being independent or dependent on support, The rejection of some candidates is "natural"

By stressing this point she contributed to lower the threshold for referring candidates who could have the potential to regain or improve their functional ability. Interviews conducted after a couple of years, indicated that they not only became more qualified to recognize who is most likely to benefit from from the new service. They also gradually realized that some of the original criteria for allotting services could be relaxed. For instance, they became more open to taking on cases that they would previously have rejected because they involved cognitive and/or psychological problems.

From the assumption that reablement was an asset for the whole service apparatus, the reablement project group established a formal network of professionals from all the above mentioned services. Besides being appointed advocates who should have a particular responsibility for keeping up the spirit of reablement, the reablement network discussed and settled routines for cross-agency collaboration. For instance, the leader of the reablement team was regularly invited to certain home care report meetings and discharge meetings in the rehabilitation and respite ward.

The reablement team gradually received more referrals from actors in the wider municipal health care system. Even some of the GPs, who had expressed scepticism at first, now had their eyes opened to the potential that lay in reablement. In addition to happy stories told in the local newspaper, information from services staff made the reablement service well known to inhabitants. This implied that a comparatively large number of people were offered reablement services in Southplace.

Northplace: Reablement as a device for off-loading care tasks

As mentioned earlier Northplace had previously followed a NPM modernization strategy and had implemented a administrative structure in which the responsibility for assessing needs and allocating services was separated from service provision at the operational level. A core aim of this administrative structure was to control costs through strict allocation procedures. The overarching aim was to target services towards the medical needs of the sickest elderly and to off-load certain home care tasks that people easily could provide for themselves. Based on a the national information system, KOSTRA (Local authorities State-Reporting system), strategy managers monitored costs by comparing their own resource use by similar municipalities. At the time reablement was put on the agenda, KOSTRA figures had recently indicated that a comparable large share of expenses in Northplace had been spent on providing help to people with moderate need for help. Hence, purchaser officers had been given a particular responsibility for off-loading responsibilities from the home care system. This implied for instance that they now made clear agreements with service users and service providers that grocery shopping, hair dressing and meals on wheels were no longer the responsibility of the home care service. Their core services were personal care and nursing care for the most vulnerable sick. Services should be reserved for people with the most severe needs.

According to the reablement project group – in which both purchaser officers and mangers from the operational level participated – this strategy was fixed. Executive managers supported the reablement project on one condition: that it would not be a cost driver. As their notions of costs were so closely linked to the annual key statistics in KOSTRA, they implicitly rejected to justify reablement as a preventative long-term cost saving service. Within their operating conditions preventative reablement was simply an unworkable idea. Nevertheless, it made sense to set up a reablement service for people who otherwise would get conventional home care service. Assuming that a new reablement service would be an

inspiration for care staff from the conventional home care, they also found it reasonable to set up the service for educational reasons. They frequently mentioned that the traditional nursing ethos of doing things *for* older adults rather than doing things *with* them was an unsustainable way of providing care. They called for a new restorative ethos of home care whereby staff were focusing more on capabilities and opportunities and on maximising the independence of service recipients. Some of the mangers admitted that a mindless way of providing prefixed care tasks had been underpinned by the purchase-provider organization. They hoped that reablement would bring back a new professional ethos whereby care staff to a larger degree would take into consideration the capacities and opportunities older people have to become more self-reliant.

Making the change of care workers' attitude a core aim, they regarded it most practical to integrate the new reablement service in the conventional home care service. Two therapists were employed both in part time position, both retaining a half position and workplace affiliation in the municipality's physio- and occupational service department.

Compared to Southplace, far fewer efforts were made in Northplace to engage professionals in finding candidates for reablement. It turned out that a relatively low number of candidates were offered the service – less that one third of the number pr capita in Southplace. For therapists and care staff the small number of eligible candidates was disappointing. One of them stated:

Informant: *We have on several occasions been informed that the person is too ill to recover enough to be self-reliant.* () *We have also been told that the person is too motivated!!*

Interviewer: *And then they think it will be more cost-effective for the person to do "self-reablement"?*

Informant: : *It seems that way, yes…'*

As the quotation indicate, the purchaser officers in Northplace were blamed for being too defensive – they did not run the risk that reablement would increase costs or be too costly for people with moderate needs. Despite the disappointments expressed by therapists and care staff, it was widely agreed that reablement was smarter way of working in the home care service. In narratives about the smart way of working economic and quality of life arguments were highly entangled. After having explained and exemplifies how older peoples' life had improved as they became more self-reliant, man informants added a story about short term cost-saving:

We've got rid of a lot of small stupid tasks - tasks we previously spent a lot of time on. For example, on making home visits in a hurry in order to help people with compression stockings. Now we educate people how to put on the stockings by themselves

Through storylines like this, they brought rablement into their overarching cost reduction narrative about off-loading tasks that people easily could handle.

6. Interprofessional practice in different context

The preceding section, demonstrates how the process of translating the idea of 'reablement' is highly influenced by the governance system in which it was embedded. Whereas in Southplace, the idea of reablement overlapped with a general push towards making the municipal service apparatus more integrated and more preventative, the service was regarded to be a device for a short-term efficiency strategy in Northplace. The divergent contextual conditions and rationales for reablement also framed the way in which actors from the two municipalities interpreted and made sense of an interdisciplinary approach.

Southplace: Boundary spanning, teamwork and mutual learning

In Southplace several forms of interprofessional work and collaboration were identified, ranging from rather loose form of networking and coordination towards highly integrated forms of teamwork. As already mentioned, above, the leader of the reablement team acted as a boundary spanner by mobilizing a whole range of professionals to contribute to the creation of a proactive referral system. Thus, the important question about who had the potential to benefit from reablement, involved a wide range of professionals: GPs, therapists from rehabilitation wards, social workers from psychiatry, nurses and nurse assistants working in the conventional home care service or in day care centres and sheltered housings. As professionals from different disciplines and services communicated with the reablement team, they all contributed to raise awareness of and to develop expertise in recognising who could possibly benefit from reablement.

Concerning provision of time-limited, intensive reablement services, Southplace found it preferable to set up an autonomous team-organization. For the reablement team leader it was unthinkable that a reablement service could work as an integral part of the conventional home care service. Her main objection to such a model was that the traditional way of prioritizing in

home care most likely would act like a barrier to the development of reablement competence. Given that the home care service was responsible for assessing needs and prioritizing between competing needs, she believed that it would easily lead to the team members, especially the nurses, being taken up with other tasks related to more urgent needs. She believed that an autonomous team organization, free of such daily prioritizing tasks, would enable reablment expertise to be developed.

The reablement team was highly inspired by ideas about interpofessionality – the idea that professionals should reconcile their differences and opposing views while seeking to optimize the paitent's participation (D'amour & Oandasan 2005, see also).The team continuously inquired and evaluated their own practices. One of the topics inquired was the use of reablement assessment tools. How can assessment tools be designed in ways that takes into consideration relevant aspect from all disciplines? And how can assessment tool be designed in ways that encourage service recipients to mobilize their own will and capacity to work intensively to recover? Based on their own experiences, check list and elements borrowed from reputable assessment tools, the team succeeded in developing an assessment tool regarded by all team members as working well in terms of facilitating interprofessional collaboration and a natural conversation with the user.

During the first year after the reablement team was set up, they were always two professionals making assessment home visits. However, as they gradually learned from each other, they became more confident to screen patients on behalf of other professions. Although they gradually developed a common core of reablement expertise, they continued to act like specialist in certain cases. In cases where the patient had pains and complications after a hospital stay the nurse would normally make some initial assessments. And, although all of the team members learned how to instruct the patient in training programs, it would always be up to the physiotherapist to change the exercises.

Despite their decision to set up an autonomous team organization for reablement, the reablement project group emphasized that their expertise should be shared with staff from the conventional home service. For that reason, an exchange program was set up inviting care staff to shadow the professionals from the reablement team for a day or two. The exchange program was at first targeted towards reablement advocates and newly hired staff. The exchange program was gradually extended and the reablement team also invited staff from the

local rehabilitation ward and the psychiatric service team to be visiting scholars of reablement. Moreover, the idea was launched that therapists from the reablement team would benefit from shadowing staff from the conventional home care service and the psychiatric service team. According to the reablement team leader, this was particularly informative as it gave them insight into some of the reasons why care staff and social workers sometimes were hesitant in referring patients to the reablement team and why it was sometimes difficult to follow up a reablement training plans. By inviting therapists into the conventional home care service an ethos of mutual learning was stressed.

To sum up (see fig 1): In Southplace various forms of interprofessional practice was taking place at various stages in the reablement trajectory. Although these practices were based on more or less interaction between professional, they accommodatet for an expanded learning context whereby employees were provided the opportunity to participate in and learn from multiple communities of practice (Fuller & Unwin 2004).

Northplace: Vertical substitution and one-way learning

In Northplace, as a core aim was to change the mind-set of care staff, it made sense to integrate the new service offer in the conventional home care service. Unlike the team organization in Southplace, the reablement service in Northplace was based on a stricter and a more hierarchical division of work. As mentioned earlier, the work of the two therapists were framed by the decision made by purchaser officers. Although, the purchaser officer communicated informally with people working in the home care service, professionals working in the purchaser unit always made the final decisions concerning who are candidates.

A physiotherapist and an occupational therapist had the main responsibility for the initial assessment, the design of a reablement program and a final appraisal. Under the supervision of the two therapists, the conventional hands-on home care staff carried out practical reablement task. In order for lower skilled care staff to carry out practical tasks, the reablement programs were often design as packages of standardized elements.

As already mentioned, the Northplace project team, put great emphasize on educating staff to change their mind-set and work in accordance with principles of restorative care. The care

department had, based on EU funds, initiated an exchange programme for employees, trainees and pupils to carry out observations and learn from colleagues in their twin municipality in Denmark In addition a regular mandatory lunch meetings were set up aiming at professional reflection among home care staff and therapists. The Friday lunch meeting was initially planned to be a mix of reflections based on certain theoretical topics and reflections based on their experiences with reablement work. However, due to the very low number of candidates for reablement, they found that the meetings were far too 'theoretical'. Topics were discussed without much specific experience to draw on. To make the meetings of more practical use, and to benefit more directly from the therapist's competency, they agreed that the lunch-meeting should be used for discussions around topics and challenges arising in their daily work. The meetings were chaired by one the two therapists who was acting in a role as teachers and instructor. Although it was characterized by a relaxed and informal atmosphere, the session had character of a classical lecture-format aiming at one-way learning.

Home care staff appreciated the Friday lunch meetings. They had learn many practical things – such as techniques related to moving patients from a bed to a chair or different types of aids that can be used in the preparation of meals. Although they were still disappointed that there were so few candidates for reablement, care staff felt that the therapists had helped them become more conscious and better at taking a more restorative approach in their daily work.. They had compiled an overview of examples of how their new way of working had given results. They used the 'list of boasts' to demonstrate for management that the focus on reablement had led to cost savings. The list included a number of examples of how simple exercises, adaptations and technical aids had led to time savings. As noted by one of the care aids: *" It has helped us getting rid of tasks".*

The interprofessional practice in Northplace had a character of vertical substitution (Nancarrow and Borthwick (2005) i.e. delegation of tasks across disciplinary boarders where the level of expertise are not equivalent. In this case it meant that the role of practical nurses were extended to include a range of task that was traditionally the domain of the therapists.

7. Discussion and conclusion

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