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**Reablement in the making – the significance of local government
organization.**

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Abstract:

Main issue analyzed

Governments around the world are aiming at changing their health care system in line with the notion of integrated people centered care (WHO). As a part of this policy shift, local governments across Norway have invested in reablement services, and strive to transform work practices in conventional home care services in line with ideas about enabling care. New service ideals are putting increased emphasis on supporting people to retain the greatest level of independence for their circumstances. Research so far indicate great local variations concerning how these new service ideals are put into practice at the front line. This paper explores the significance of local government organization in shaping the implementation of new restorative an enabling care practices.

Methodology – source of data

The paper is based on a cross-case analysis using data from a follow-up study (2014-2017) in two Norwegian municipalities. A range of data sources are utilized: Local policy documents, administrative data, information from local meetings and workshops, interviews with key actors such as local senior managers, purchaser officers, front line managers, senior professionals, and volunteer coordinators. The research team has organized twelve group reflection sessions among care staff and have shadowed care staff in their daily work. In this paper data is analyzed and interpreted through the lens of a ‘contextualist’ framework.

Main findings

A key finding is that municipalities live in the shadow of their institutional past. The paper demonstrate how efforts to change work practices in home care are influenced by power relations and institutionalized norms and practices established under earlier administrations. Whereas one of the municipalities had previously modernized their government organization in line with New Public Management (NPM) ideas, the other had largely retained a bureau-professional mode of organizing care. Although both municipalities had chosen a bottom-up employee driven strategy for the implementation, care staff perceived the prerequisites for change differently. Staff from the NPM municipality perceived that they were highly constrained in their efforts to adopt new work practices, partly because NPM structures had not been deinstitutionalized. Needs assessment and allocation of services still was in the hands of a centralized purchaser unit. In the municipality previously regarded a “NPM-laggard” work practices were more extensively changed in line with new service ideals. The findings indicate that new service innovation taken from the New Public Governance (NPG) agenda are highly contingent upon the local government organization. Unless managerial power is shared with care staff in such a way that they are able to respond adequately to the contextual and shifting needs of service users, new service ideals may easily be implemented in a superficial way.

Introduction

Population aging generates challenges for governments to enhance healthy ageing and minimize cost pressure on public services. The World Health Organization (WHO) call for a paradigm shift in health and social care provision that seek to optimize the intrinsic capacity of people with complex and chronic diseases and to enable families and communities to become actively engaged in co-producing care services in partnership with public care providers (WHO 2016). Echoing this global strategy, the Norwegian Government recommends that health and social care services should better utilize interdisciplinary expertise and work more preventative and proactive in order to enable people to make greater use of their own coping capacity.

The most popular initiative aiming in this direction is *home care reablement* – commonly defined as an early intervention, time-limited, multi-disciplinary and home-based intervention. A core element of reablement is to focus attention on outcome goals that matters to the older person, not to the therapist or the care worker. The ultimate aim is to re-establish or maintain daily living skills, as well as community participation, for elderly patients, and thereby enhance their physical, emotional and social wellness. From a social investment perspective, this strategy is also regarded to enhance the capacity of the welfare state to handle the societal risks associated with the population ageing (Rostgaard 2016). Reablement is an idea that seem to have the hallmark of being a “magic concept” (Pollit & Hupe 2011) – it is broad, has a positive normative charge and a seeming ability to dissolve previous dilemmas between quality and cost efficiency. Yet these characteristics hardly seem to hinder an rapid and a widespread usage. For governments facing an increasing cost pressure on services for older people, the idea seem to stand out as the obvious right thing to do.

So far, the principal focus of research commissioned by governments have been on outcomes – whether the intended outcomes of reablement really are attainable. (Tuntland et al 2015,2017). The overriding focus on outcome may however easily disguise the fact that reablement is a rather ill-defined intervention targeted towards an ill-defined and potentially heterogeneous population/patient group (Legg et al 2016). Although positive benefits have been identified in several studies (Glendinning et al 2010, Langeland et al. 2016) it is still unclear what constitutes reablement and what elements of intervention are critical in determining its effectiveness (Tuntland et al 2017). There is also a paucity of research on reablement in practice (Steihaug et al 2016). Moving beyond the focus of decontextualized

intervention studies, it is unclear how practices of reablement are embedded in different social, political, cultural and historical contexts.

In health care research, there is an increasing plea for research that draws attention to the way in which interventions are shaped within and through the multiple interconnected social relationships and processes that constitute the 'real world' (Dopson et al 2008, Fulop 2014). The aim of this paper is to increase the momentum of this emerging field of research. Drawing on case study data from two different municipalities this paper explores how the idea of home care reablement has been grafted onto existing institutionalized power relations practices. Particular attention will be paid to the way in which the process of change is indirectly influenced by the government organization of the two municipalities. The paper argues that the different modes of organization allow for different allocation practices which again influences the learning context of care staff. Before turning to the empirical analysis part, the paper starts by giving a brief presentation of the historical institutional context of the Norwegian home care system.

The history of Norwegian home care

In Norway health and social care, including home based care, belongs to a comprehensive infrastructure of tax subsidized services offered to and used by all social groups. The relatively strong welfare commitment between government and citizens has developed within a complex system of multilevel governance. Although central government exert influence on local governments through legislation, funding, instructions, guidelines and so forth, local authorities are given free hands to manage and organise services the way they want.

The autonomous role of local authorities consolidated through a comprehensive set of decentralization reforms which 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. Moreover, a generous funding system whereby considerable costs for care were reimbursed by the state was replaced by a system based on block grants. Hence, from then on it was up to the local government to find cohesive and cost effective care solutions.

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, proximity and user

participation. Municipal home care was typically organized in self-regulated teams, whereby considerable decision making power was delegated to front-line staff who are working directly with people. This was justified on the ground that staff are dealing with contextual, complex and shifting needs (Vabø 2011). Very much alike the normative ideas behind reablement, the care ideology of that era was to encourage and support the older person to utilize their own strengths and resources. The ideal care recipient was depicted as an active person willing to utilize their own ability to provide self-care rather than making demands for public help (Vabø 2011).

However, during the 1990s the ideal of providing help-to-self-help faded as it was overlaid by competing ideals suggesting that citizen should have the right to clear service entitlements. Initially, a range of regulations was made aiming at improving the transparency of local service provision and making the legal rights of citizens more enforceable. All these regulations called for more explicit allocation criteria and work procedures (Vabø, 2011). Overlapping this trend of regulations, a wave of New Public Management (NPM) reforms encouraged municipalities 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 became a cure all model promising that local authorities would now be in a better position to make quality demands and subsequently to control costs and manage quality at arm’s length and at the same time in a better position to specialize on the legal and formal aspects of service allocation. Service staff was promised to be relieved from the burden of prioritizing between competing needs.

In many municipalities, the purchaser provider split formed a part of a strategy of cost reduction whereby service elements were tacitly off-loaded from publicly funded home care (Vabø 2012). Being closer to the budget holding unit, the purchaser authority made sure that citizens were offered a minimum of predefined services – *“this is what you are entitled to – nothing more, nothing less.”* The model represented a radical break with the previous situated approach to service allocation. By handing over discretionary power to specialized gatekeepers, the role of skilled care workers as creative enablers was de-emphasized (Vabø 2011, 2012) and the previous person-centred approach of providing help-to self-help was more or less replaced by a task based approach.

Although the purchaser-provider model worked to intensify care work in many municipalities, a substantial number of municipalities did *not* implement the model at all, but preferred to adapt to legal requirements within their bureau-professional service apparatus. Furthermore,

in order to enable care staff to continue to attend to urgent and unstable needs, many municipalities opened up for rather heuristic version of the model (Vabø 2012, 2015).

Being grafted on to several layers governance arrangements rooted in more traditional public sector values, NPM have not displaced previous modes of governance, but created a field of tension whereby actors are maneuvering between competing discourses and logics of governance (Vabø 2015). Concerning the prevailing ideas of reablement it is important to take into consideration that the idea will have to be translated within a complex organizational context which is more or less penetrated by service ideals rooted in preceding waves of reform.

Travelling ideas meet local contexts

In Norway it is widely agreed that reablement is an intervention aiming at maximising the capacity of people to live independently at home. The intervention is time-limited, multi-disciplinary and provided in peoples own arena. Although there are general agreements around these broad principles, they can be subject to different interpretations and specifications. For example, there may be different interpretations of what disciplines should be involved, how early interventions should be made, how comprehensive efforts should be and what arenas should be considered as the user's arena. Like other ideas and precepts aiming at successful service provision, reablement appear to be a 'semi-finished' concept e.g a concept that must be interpreted and clarified before it can be of practical significance (Røvik 1998).

Research focusing on way ideas are spread to different local contexts often highlight that popular ideas (like reablement) do not diffuse in a vacuum but are actively transferred and translated in a social context of other ideas, actors, traditions and institutions (Sahlin & Wedlin 2008:219). The process of interpretation and translation may take place in many different arenas and levels of an organisation (Czarniawska & Joerge 1996) and will be "filtered "through many different heads and horizons of understanding. Czarniawska and Joerges (1996:27) use the concept of 'perceptual readinesses' in order to highlight that people see different ideas in texts depending partly on what they expect to see, partly what they are able to notice in terms of categories accessible to them. Unfamiliar ideas can pass people by without being given any attention. A particular idea can be perceived by some actors as something that is a matter of course or something that is already known and by other actors as

new insight (an eureka moment) that changes a person's way of thinking and acting.

Understanding and insight are often acquired gradually and can therefore lead to the discovery of new aspects of an idea as new knowledge is acquired. Hence, the process of translation will often evolve over time.

When people in positions of authority have become convinced that the idea is sensible it may still be required that many other people will have to participate if the idea is to materialize. According to Czarniawska and Joerges (1996), follow-up by employees depends partly on how the concept is presented. When employees are presented with a message without any context, it may 'glide past' without being recognised as something that relates to a person's own practices. When a controlled learning process takes place, in which employees in the organisation are exposed to examples that can be related to their own daily lives, it is more likely they will perceive the concept as a source of new insight into how their own practices can be changed. It is essential that the concept is translated in a way that gives meaning in a specific everyday context.

Czarniawska and Joerges' notion of the translation of ideas correspond to the general processual and contextual approach of Pettigrew et al (1990) who argue that analysis of planned changes should take into consideration both the horizontal and vertical dimension of contexts. The horizontal dimension refers to the sequential interconnectedness of phenomena in the past, present and future. Initiatives taken to make improvements are then seen as continuous, interdependent sequences of actions and events. Actors involved will explain the origin, continuance and outcome of an initiative using the language of 'becoming', rather than 'being'. The vertical dimension refer to the interdependencies between higher and lower level of analysis phenomena, for instance how political decision and structural arrangements may indirectly influence the way learning environments are created on a practical level of service provision. The significance of a learning environment or learning climate is an emerging sub-theme of contextualist research on organizational change. Drawing on the theory of situated learning (Lave & Wenger 1991) which takes its focus in the relationship between learning and the social situation in which it occurs, (Fuller & Unwin 2004) suggest that learning environment may be more or less expansive e.g. more or less stimulating, motivating and amended for personal and professional development. They emphasise for instance the relevance of boundary crossing between multiple communities of practice and the valuing of knowledge and skills of the whole workforce, not just key staff.

The case studies

This paper is based on case studies conducted in two different municipalities between 2014-2017. Both municipalities are located on the south-western coast of Norway. One of the municipalities, Southplace, has approximately 15 000 inhabitants, of which about one fifth live in a rural area stretched over 432 km² of sparsely populated coastline and moorland. Northplace has roughly 43 000 inhabitants and extends more than 230 km² over a large island as well as some smaller islands and a peninsula on the mainland. The majority of the population is concentrated in four to five small towns, but even here much of the population is dispersed over a rural coastal landscape.

The case studies were conducted in conjunction with a research and innovation project. In a preliminary project conducted in 2013 the municipality of Southplace had been involved in creating a common learning platform for researchers and care staff on reablement. In the new project, a comparative element was added. By comparing the processes of reablement implementation in different local contexts, a better insight would hopefully be gained into what factors could be expected to hamper and expedite the restructuring (Pettigrew 1990). The municipality Northplace was chosen as they had organized their service apparatus differently than Southplace. Whereas Northplace had centralized the gatekeeper function and organized their services in line with the purchaser -provider model, Southplace had continued to delegate the gatekeeper function to service providers.

The project was conducted over three years. During this period, many different types of data were collected at various levels in the municipalities. Interviews were conducted with managers, case workers and various professional practitioners. We arranged several reflection groups with staff, as well as seminars where preliminary experiences and insights were discussed and shared across the two municipalities and in discussions with representatives from other municipalities. Interviews and reflection group sessions were recorded and transcribed. In addition, notes from observations, meetings and conversations were taken. Data was analysed as an ongoing process, with the researchers' notes on their reflections being reported back to and discussed with practitioners.

Starting home care reablement

The concept of home care reablement was put on the agenda in 2012 as both municipalities had arranged for a study trip to Denmark. Like many other Norwegian municipalities officials from Southplace visited the city of Fredericia – the Danish municipality commonly used as a best-practice standard for reablement in Norwegian local authorities. Northplace visited its twin municipality in Denmark, Holstebro. When the research project started in 2014, the two municipalities were at different stages in the implementation process. Southplace had already established a reablement team in the spring of 2013. Northplace had chosen to start with a training initiative. Based on their cooperation with Holstebro they applied for EU funds to implement an exchange program – a training programme for employees, trainees and pupils to carry out observations in the twin Danish municipality of Holstebro. The following year, they started a pilot project for home care reablement, which was linked to one of their service districts. When the municipality granted two extra full-time equivalents (FTEs) to strengthen the physiotherapy and occupational therapy service in the municipality, the management of the health and care services chose to use one of these FTEs in a pilot project on reablement.

In a kick off seminar held in 2014 actors from both municipalities shared great enthusiasm for the idea of reablement. They talked about the idea in line with the general official definition (see above). In addition, they agreed that reablement was a ‘smart’ way of working that they hoped would permeate the ‘conventional’ home care service and thereby contribute to more cost-effective operations. In order to emphasise the importance of achieving a pervasive shift in mentality, many of their arguments were backed up with a self-critical focus on their previous work practices. Various examples and stories were presented about the previous practices of squandered resources and misunderstood care. One of them stated, for example: *‘We nurses need to be so nice. It’s so easy for us to think “What a shame – they are so old”, and so we do it for them. I think it’s wrong. It deprives people of their dignity and self-respect. We must be better at putting our hands behind our backs and making sure that the elderly can manage to do things for themselves. It’s often easier to do it for them – but that’s not what we ought to do.’*

In order to facilitate a change in mentality in the conventional home care service, both municipalities organised a joint workshop for all employees in the service. Employees heard experiences from other municipalities and were told about the various presentation videos available on the Internet. Both municipalities emphasised that training should not only take the form of theoretical education but also practice-based learning through observation

schemes and professional reflection (more about this below). Viewed in light of Felstead et al. (2009) concept of expansive learning environments the plans of the project leaders reflected that the process of learning should be rooted in the real world of practice. It was meant to be more than simply nice words.

Adapting to the historical institutional context

There was thus agreement across the two municipalities that the aim of their efforts was to establish a new defined reablement service aimed at persons living at home who had experienced a significant functional decline. Moreover, the aim was to ensure that the employees in the conventional home care service adopted a mind-set of working to enable older people and their families to enabling people and their families to reduce their risk of developing new long-term conditions or to live more comfortably with existing ones..

It soon became apparent that the concept was translated in rather different ways in the two municipalities. The disparities were initially manifested in their choice of different organisational models. In Southplace, it was decided that home care reablement should be the responsibility of an independent team of professionals – an occupational therapist, a physiotherapist, a nurse and a health care worker. The team would act as a ‘spearhead’ in the work, but in order to ensure that the team did not act in isolation from the rest of the municipality, resource persons from the conventional home care service. These resource persons were to have a special responsibility for following up patients who had received assistance from the reablement team, as well as a special responsibility for raising awareness of the enabling way of working.

In Northplace, it was argued that home care reablement should be closely integrated with the conventional home care service. On this basis, it was decided that the rehabilitation should be carried out by the home care service staff (nurses and auxiliary nurses) in collaboration with a physiotherapist and an occupational therapist who were attached to the municipality’s regular physiotherapy/occupational therapy service.

The fact that the two municipalities chose such different organisational models reflects a pattern that was highlighted in several reviews and research contributions on home care reablement. A review of Norwegian examples of reablement (Næss 2014) indicates a wide organisational diversity, but notes that it is possible to make a rough distinction between (1)

independent teams that are organised in parallel with the conventional home care service and the rehabilitation service, (2) teams that are organised under the conventional home care service, and (3) teams that are organised under the rehabilitation service. In view of what we know about Norwegian and Nordic local democracy, this is not surprising. The municipalities have a relatively large degree of freedom to tailor their service provision to what they consider most appropriate for local conditions such as sizes of population, demographics and topography. When a new service such as reablement is to be established, the individual municipality will naturally ensure that it will function as a complementary service to the existing services.

In Southplace, it was unthinkable that a reablement service could be set up as an integral part of the conventional home care service. The main objection to choosing such a model was that it would be difficult to develop competence across five different geographical zones. Moreover, as the home care service had the responsibility for prioritizing between needs, they believed that it would easily lead to the team members, especially the nurses, being taken up with other tasks related to more acute needs. An independent team that was free of such daily prioritizing tasks would enable expertise to be developed in reablement. In Northplace, however, it was argued that the best option for the pilot project would be to test home care reablement as an integral part of the conventional home care service. The choice of organisational model was based on the notion that it would probably be easier to spread knowledge of the principles of home care reablement to *all* employees if the services were integrated. It was also pointed out that the municipality had already established a mobile interdisciplinary rehabilitation team that worked throughout the municipality. This team has some features in common with an independent reablement team in that the rehabilitation takes place in people's home. However, it is concerned with rehabilitation that is based more on medical expertise, and is more geared towards restoring certain functions (e.g. mobility and speech after a stroke) as opposed to mastering everyday tasks and activities.

Concerning the impact of the different administrative structures of the two municipalities we found that it had great influence on the way home care reablement was allocated. In Southplace, where the responsibility for allocating services was decentralised to various service units, it was a matter of course that all enquiries and applications should be sent directly to the team. In Northplace, on the other hand *all* enquiries and applications for services are channelled through a centralised purchaser unit. It was never questioned whether reablement should be allocated differently.

Different allocation procedures in operation

When the reablement team in Southplace launched the service, the head of the team was given a large degree of freedom to design the service at her own professional discretion. She was responsible for developing procedures for allocating and following up patients, and for sharing knowledge with the conventional home care service. Prior to start-up, intensive efforts were made to spread knowledge about the new service. She took it upon herself to visit the five home care service zones, the local rehabilitation ward, the central hospital in the region and the primary care doctors. Information about the service was provided in the waiting rooms of doctors, physiotherapists and other health care services, and details were published in the local newspaper. .

The service was initially aimed at adults who were considered to have the potential to improve their level of functioning or to manage with less assistance. It was particularly relevant for new clients i.e. people who had never used the care services before, but also for those who were already using the services but who would have qualified for more assistance as a result of a functional decline. In principle, one of the requirements was that the person was motivated to do more for themselves. Initially, it was decided that people with cognitive impairments and major mental health problems would be excluded. There was also a conscious decision to steer clear of people with a single functional impairment; the service should be reserved for people with multiple issues – typically older people.

At start-up, the team made a great effort to find candidates who might meet the criteria. From the idea that reablement will prevent and ease of pressure on the whole service apparatus a range of service providers were approached. Managers and staff from the regional and municipal rehabilitation wards were called on to consider whether they had candidates who were motivated and ready to receive home care reablement instead of institution-based rehabilitation. Managers and staff from the home care service were encouraged to pay attention to whether any of the home-dwelling service users were starting to feel insecure about staying at home and would benefit from assistance to help them cope. The reablement team leader encouraged them to make referrals also in cases where they were in doubt if the person was suited. The team's motto was that it is better to refer too many than too few. This has to be expected when searching for people who are in a difficult grey zone between dependence and independence.

The consequences of the proactive strategy in Southplace were that they managed to elicit a large number of referrals, most of whom received reablement, but some were rejected after assessment. During the first two months, a total of 25 people were referred – seven of whom were rejected after being assessed by the team. The service gradually became known to inhabitants, often via the staff of other parts of the service organisation or through word of mouth. The local newspaper presented the new service innovation and the leader of the reablement team, followed by a happy stories about older people who had regained their functional capacity and returned to their daily activities. The team participants experienced to receive positive feedback from many actors in the wider health care system. Even some of the doctors, who had expressed scepticism at first, now had their eyes opened to the potential that lay in reablement. In 2016 a total of 196 were referred, 124 of them offered the service.

Through interviews and reflection groups during the first year, we heard many stories from Southplace about how the team worked with people. These stories was very much about enabling people to self-care like getting out of bed or putting on stockings. We did however also hear about enabling work performed outdoor – for instance helping the old fisher to relearn driving to the harbour and boarding of the smack; or helping an old woman to be able to walk to the café to meet with her friends.

The increasing number of referrals meant a greater diversity of experiences for the reablement team members. This led to the relaxation of the original criteria. The team became more open to taking on cases that they would previously have rejected because they involved cognitive and/or psychological problems. Likewise, they gradually relaxed the requirement for motivation, and started accepting more people who were demotivated and needed a gentle push to get started. In line with Moe and Brinchman (2016) they learned that some people needed motivation and a helping hand to start and sustain physical activity. They had also experienced that depressed people needed a helping hand with practical task in order to find the energy to look after themselves.

Northplace chose a different strategy at the start of its pilot project. The project was to be carried out in the largest of the municipality's six units for home-based care. A steering group was set up for the project, and two half-time positions were created for a physiotherapist and an occupational therapist – both located in their own service department. In addition, the municipality received additional funding from the Norwegian Directorate of Health to participate in a national follow-up research project. These funds paid for a care worker in the conventional home care service who would follow up on national research and strengthen the

competence of the project's steering group and of the reablement resource group i.e. therapists and staff who had a special responsibility for following up the day-to-day work in the home care reablement service. Unlike in Southplace, it was intended that all employees of the conventional home care service should carry out the actual work of reablement. A great deal of emphasis was therefore placed on skills development among home care nursing staff. Adding to the observation program in Holstebro, two half-day courses were organised and regular mandatory lunch meetings were held for training and professional reflection together with the two therapists employed.

Due to resource shortages, it was emphasised that the criteria for receiving reablement should be relatively strict. The service should not be offered as a preventive measure, but should primarily be provided to persons who had a statutory right to the necessary medical care. Thus, there was a focus on providing reablement in typical cases where it was a realistic prospect to avoid that an elderly person would develop more comprehensive care needs. It was the purchaser unit that had the decision-making authority to decide whether a person had a potential for reablement. The municipality thus placed relatively little emphasis on marketing the service. They provided information about the pilot project on their website, but the brochure explaining the service was not given to the individual patient until after the purchaser unit had decided whether or not they met the eligibility criteria.

The financial considerations were highlighted in several of the interviews with managers and care staff in Northplace. In the interviews with the employees, for example, it emerged that the time available to spend with the person who was receiving reablement was restricted. In practice, there was limited time for the users to practise exercises. If a user wanted to practise going out to the post-box, they had to rely on their family caregiver. There was not normally any time for more than a few exercises and practising daily care tasks. This impression was confirmed by informants at the purchaser unit. They emphasized that reablement is a way of providing care related to 'daily activities', i.e. what people do when pottering around at home. According to the physiotherapist from the reablement group, the reablement intervention is normally fairly simple as they have to be managed by all employees.

After the pilot project was over, it became apparent that relatively few people had received a decision on reablement. During the two-year period of the scheme, only 30 people met the eligibility criteria – some of them were too frail to carry through. For the therapists and the health care workers in the reablement group, the lack of suitable candidates has been a disappointment. The preparatory training initiatives and in particular observation visits in

Holstebro had inspired them to believe that reablement is a sensible and appropriate way of working. Their disappointments were partly expressed through stories about the very favourable contextual conditions observed in Holstebro, for instance, that physio- and occupational therapists formed a part of the home care team on daily basis. However, they also expressed frustration over the way the service allocation system worked in Northplace. In a focus group interview, employees said the purchaser unit was a bottleneck as they lack insight into the everyday lives of individuals. As long as case workers spend most of their time in the office it is impossible for them to find out who are suited to reablement. Working solely on the basis of the information supplied by the hospitals makes for a flimsy foundation. It may appear from a person's records that they are suitable, but the reality is often different. The informants in the focus group had also experienced the other side of the coin: people who had been discharged from hospital with a decision for comprehensive care could have managed to become self-reliant if they had been offered reablement instead. One employee explained:

'We have tried to speak up about this. For example, someone were discharged from hospital on a Tuesday that we thought would be well suited. Then we reported back to the purchaser unit and expected to receive an answer on Thursday – because that's when they hold their meetings. But we didn't hear anything. Another whole week passed before we got a reply.'

The informants from the reablement group had encountered resistance from the purchaser unit on occasion.

'Member reablement group: We have been informed by the purchaser unit that the person is too ill to be self-reliant. But it surely isn't a criterion that a person has to be fully self-reliant? It's also about reducing the need for assistance.'

Interviewer: Why did they made this decision? Is it because the potential cost reduction is then regarded to be too low? Or is it because they don't believe that the person is not motivated?

Member reablement group: Yes – maybe. But we have also been told that a person is too motivated.

Interviewer: So they think it will be more cost-effective for the person to rehabilitate himself/herself?

Group member: It seems that way, yes... (laughing)

In interviews with case workers from the purchaser unit, it was confirmed that they could represent a bottleneck in the system. It is a part of their work role to keep an eye on costs and to make sure that services are rationed in a just manner. They did however also admit that the purchaser- provider system did not work the way it was intended to work. In the planning for the new reablement service they had considered case workers from the purchaser unit should make home visits to assess whether patients are suitable for home care reablement. However, in practice, there is rarely time for making these visits. As older people are discharged from hospitals sicker and quicker, the caseworker sometimes has to make a service allocation decision within a few hours. And, as case workers are not working around the clock, and do not have the capacity to be on standby for when the patient comes home from the hospital, assessments are often solely based on the information from the hospital and a phone call with the patient. A caseworker explained: *“In practice, reablement is seldom granted the first day after being discharged. People coming straight from the hospital are generally far too ill to start thinking about reablement. At this stage they are in need of ...and they are entitled to receive required medical care. Whether reablement is a realistic option on a later stage is up to the nurses working in the home care service to assess. The nurses then have to report back to the purchaser unit, which subsequently makes a decision.”*

Although the home care provider had agreed upon this practice it was not always easy for them to find the time to probe and evaluate whether a newly discharged patient is suited or not for reablement. According to the same caseworker, they had met criticism:

‘The employees who work in the home care service say they do not have the capacity to take over our job. I can understand that. But it is not easy for us either. We get large volumes of new enquiries.’

Both managers and employees from Northplace said that the issue has been discussed in the reablement group and in the steering group. In order to solve the problem, they had agreed that, instead of passively waiting for a decision from the purchaser unit, they should work on the assumption that *all* new clients will receive enabling care. It does not have to be called ‘reablement’, and it is not necessary to undertake the whole gamut of measuring performance and progress. The intention must be for everyone to ‘work smarter’, with a view to the client being as self-reliant as possible.

Even though very few clients had actually received the specific service ‘reablement’, the local authority in Northplace decided by the end of the pilot period that the service ‘reablement’

should be implemented in all their home care districts. They thought it was important to hold onto the specific service offer in order to maintain a focus on training and systematic working. The underlined however that the *real benefit* of the service was not narrowly linked to the benefit for those who receive reablement, but for all older people in need of care. In their own internal evaluation of the pilot project, they used what they referred to as ‘positive side effects’ to argue that the project had given an unexpected benefit as it had pushed care staff into the right mind-set. The employees have generally become more conscious of not providing help where a person can manage with just simple adaptations, assistive devices or by supporting the older person to build confidence in her/his own capacity to manage daily tasks.

Although all parties admitted that the division of responsibilities between purchaser and provider made it difficult to find suitable candidates, no one was suggesting that the system needed to be changed. The defensive approach to trying to identify more potential candidates was highlighted by several of the administrative managers questioning how cost-effective it was to invest in intensive reablement. These doubts were supported by the recent national evaluation, which revealed that home care reablement probably increases function and quality of life, but there is no evidence to suggest that costs can be reduced over time (Langeland et al). Hence, the idea that the specific service ‘reablement’ was cost-effective was toned down and the aim of changing the mind set of home care staff was highlighted.

Learning the art of enabling older people

Research on home care reablement has highlighted the challenges of implementing the service in a care culture where the main rule is to compensate for the elderly’s functional disabilities (Rostgaard & Graf 2016). Therapists and others who work in reablement sometimes find that their efforts are ‘countered’ by well-meaning helpers insisting on doing tasks *for* the service user. This is particularly in evidence in cases where the person undertaking home care reablement is also receiving services from the conventional home care service. One of the therapists in Southplace told us the following about just after they started the new reablement service: *‘There was someone who had entered into an agreement with us to be as self-reliant as possible. Then we heard that the home care staff who had been there in the evening had washed her hair without checking whether she could do it herself. It seems that they did it purely as a matter of routine, without considering whether she could do it herself.’*

Countless versions of such stories can be found and are often used to illustrate why home care reablement requires a change in mentality of the whole service apparatus. As mentioned earlier, it was a core aim for both of the municipalities involved that the mind-set of enablement should permeate through all of the home-based care services. The aim was for all employees to optimise the clients' own capacity to regain and sustain independence.

In Southplace, where an independent team was providing reablement, several initiatives were taken to transfer the mastery mind-set to the conventional home care service. An 'ambassador' was appointed for each group of home care staff who would have a special responsibility for ensuring that the person who had been or was still going through a reablement process was followed up in line with the plan devised by the therapists. Moreover, 'the ambassador' would more generally be responsible for spreading the knowledge about reablement and ensuring a continued focus on it. Together with 'ambassadors' from other services (the local rehabilitation ward, and the psychiatric service team) the 'ambassadors' took part in reflection groups facilitated by two researchers. The aim of the reflection group was to make explicit staff experiences of taking on an enabling role and to discuss dilemmas and challenges working to enable older people to regain their functional capacity. A popular and educational initiative among home care staff in Southplace was an observation scheme where they were given the opportunity to shadow the reablement team for a day or two. They also found it useful that the leader from the reablement team participated in meetings where they discussed why and why not patients could potentially benefit from home care reablement. These meetings were also regarded useful for the leader of the reablement team. Being in close contact with the staff from the conventional home care service made her more aware of the complexity of the needs and the capacity of clients. Based on this experience, it was decided to expand the observation scheme and invite members from the reablement team to shadow the conventional home care staff. Hence, the learning environments expanded and became to a larger degree bidirectional.

The aim of making the way of working known to all employees in the conventional home care service had high priority in Northplace. In fact, it was the main reason for developing an integrated model of reablement. In addition to the observation scheme in collaboration with Holstebro, care staff appreciated the mandatory Friday lunch meetings facilitated either by the occupational therapist or the physiotherapist.

In a focus group interview, employees told how the topics discussed at the lunch meetings were slightly different to what was envisaged, simply because they had so few specific cases to discuss. They had planned for an arrangement where participants would switch between thematic discussions and reflections on experiences gained in the work on reablement.

However, after a while 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 gain more direct benefit from the physiotherapist's and the occupational therapist's competency, they agreed that they should use the meetings to discuss specific cases from the conventional home care service. By doing so, they felt that the reablement pilot project had a positive effect of high value.

A new ethos care ?

Home care staff in both of the municipalities agreed that the focus on reablement had influenced their own practice. While they had previously performed tasks in line with work plan instructions without questioning what the clients actually could do themselves, they had now become more conscious of exploring the functional ability of patients and encouraging them to manage everyday tasks themselves. Several of them mentioned that they thought that an enabling approach was a meaningful and more professional way of working. It was satisfying to experience how the older people appreciated to regain their capacity to manage everyday life. Although we heard stories about employees who were still stuck in their old ways and busy situations where it took too much time and patience to wait for the client to do things for themselves care staff confirmed that altogether reablement had clearly changed their care practices. As described by a nurse from Southplace: *'When you hear the term 'home care reablement' – it triggers something.... It's not just words. We now have a new awareness in our work'*.

Despite the similarities in their general opinions, the more detailed stories about their learning breakthrough moments were clearly influenced by the different learning environments created in the two municipalities. The Northplace employees' eureka moments were largely linked to the contact with the physiotherapists and occupational therapists. They described the teaching mode as an expository kind (Bruner 1961 cited in Czarniawska &

Joerge) they were exposed to new knowledge from the two teachers – the two therapists. They found that the therapists made them aware of things they would not otherwise have seen. One described it as follows: *‘They see things in a different light from us.’ They also had many good tips and tricks that are useful to know.*

As an example, one care worker described an episode where she had observed how a stroke patient had walked up stairs together with the physiotherapist. She did not think it was possible. She had almost automatically wanted to help the patient up the stairs. Observing the physiotherapist at work had obviously inspired her: *‘When I saw how she did it, I felt I could do the same’.*

In the Friday lunch meetings, they had discussed many useful and practical things – such as 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 disappointed that there were so few candidates for reablement, the staff felt that they had become more conscious and better at taking a more enabling approach in their work. This required patience – they had to slow the pace to let the client try to discover what could be achieved. It also required ‘explanatory work’ – where the client learned how it would be beneficial for them to not have to wait for someone to come in to help them. They had compiled an overview of examples of how simple exercises, adaptations and technical aids had led to cost savings. They used this ‘list of boasts’ to make it clear that the focus had given results.

In Southplace similar stories were told of how practical and functional adaptations could give the client more freedom *and* at the same time lead to cost savings. However, stories from Southplace staff reflected that they had been exposed to and had participated to a larger variety of specific cases. For instance several of their examples pointed to how they had learned to get reluctant and demotivated patients to ‘turn’ through a give and take process. One nurse described how she experienced an aha-moment as she watched the occupational therapist in an encounter with an elderly woman who could not be persuaded to use a walking frame to go out. She had greatly appreciated the walking frame in the hospital, but using it in public was a different matter altogether. Instead of trying to explain to the woman and convince her how much better life would be if she used the frame, the occupational therapist asked if she was embarrassed to go out into the community with a walking frame. The elderly woman admitted that she balked at the idea of others thinking that this is how she ‘had ended up’. The therapist acknowledged that ‘a lot of people feel like that’. By taking a break and giving the woman some time to think through her own reasons for not using the walking

frame, she managed to turn the woman without direct persuasion. The woman agreed that she could perhaps test the walking frame out if she wanted to get some fresh air in the courtyard or in town when there was no one around. Observing this situation had worked like a eureka moment for the nurse as it made her realise how she could apply what she had learned in a motivational conversation course.

This learning outcome stories from Southplace reflected how much they were working at the outer limits of the physiotherapists' and occupational therapists' knowledge and moving towards a psychosocial field that was more akin to getting people to retain their desire to live than about keeping them on their feet. This also meant that nurses became more aware of their own social skills and tacit knowledge.

The leader of the reablement team (the occupational therapist) explained that she was dependent on the skills of nurses – their professional skills as well as their social skills. After having experienced many complex cases she had learned to identify a category of clients who often failed to benefit from the reablement, even though they wanted to. It was often those who were very old and fragile who appreciated and were cheered up by a visit from the occupational therapist, but who were unable to be diligent about practising exercises after the therapist had left. From this experience she had come to an agreement with home care staff that these clients would be offered a “light” version of reablement i.e. a more proactive and person centred approach to care. The way of handling these marginal cases was one of several signs suggesting that the reablement service had mobilized nurses to utilize their own professional knowledge to optimize the capacity of the frail older person beyond the physical achievements.

Asking people from the conventional home care service about *whether* and *how* their service had changed after the reablement team was set up, a recurrent answer was : “*We have been more aware of asking ourselves: how can we help this person to carry his/her life at home*”.

They had also been more aware of not making long term agreements and more attentive to the potential capacity of the older people. Registered nurses of the home care service had copied parts of the reablement assessment questionnaire, but had edited some of the questions in order to make them better fit with aspects relating to nursing care.

Whereas many of the informants from Southplace talked about their own learning outcome in a holistic manner, care staff from Northplace attributed it mainly to what they had learned from the therapists. Thus, the implicit conception of reablement' in Northplace was more

narrowly linked to the physical capacity of older people – to their capacity to manage their own personal care and domestic chores. They had been more aware that even frail older people are able to enhance their own physical strength and capacity.

Discussion/conclusion (this part is incomplete)

The Norwegian public home care system has been in a constant process of change ever since the service developed in the early 1960s. The service which was traditionally characterized by generosity, flexibility and person-centredness has gradually been marked by a quest for bureaucratic accountability and, like home care in most western welfare states, by the ethos of new public management (Vabø 2015). These changes have contributed to support predictability, consistence, rigour and certainty, but have made it increasingly difficult for care staff to respond adequately in difficult situations. However, in recent years, innovations such as reablement is taking place, which point in a different direction and is blossoming in several places at once. Moreover, it is gradually recognized that it is a waste of resources not to exploit the assessments of employees and their ability to prioritize (Hvid & Kamp 2012).

Drawing on a cross case analysis from two different municipalities this paper has explored how the idea of reablement has been translated and put into practice in different real life context. The analysis demonstrate how different ways of steering and organizing the service apparatus have influenced the implementation process at different levels:

Firstly, it influenced the solution to the problem of determining whether reablement services should be organized as autonomous team or as an integral part of the conventional home care groups. In Southplace, where needs assessment and service allocation was a delegated responsibility of the service providers, the autonomous team model was preferred simply to ensure that staff resources (earmarked for reablement) was not absorbed into other task. They knew from experience that care task in the home care system are sometimes diminished by the needs of patients with urgent care needs or by the unpredictable influx of sick elderly requiring the care giver's attention. In Northplace, where the responsibility for needs assessments and service allocation is centralized to a purchaser unit, the preference for an integrated model was obvious. Reablement was seen as a new kind of "service package" adding to packages based on conventional care tasks.

Secondly, the service organization influenced the way candidates for the new service were recruited. The reablement team leader of Southplace was delegated the responsibility to

advertise the new service towards other service providers in the municipality and towards the general public. The team operated on the inter-organizational (horizontal) arena of the municipality and encouraged professionals from different disciplines and service units to consider whether any of their patients could possibly benefit from a time limited reablement intervention. The motto of the team was that making too many home visits is better than making too few. In contrast to the open inviting approach of the Southplace team, the purchaser officers working in purchaser unit in Northplace did not advertise the new reablement service at all, but adapted to the new allocation criteria of the new service offer. Being committed to the aim of controlling cost and ensuring “equal treatment,” and “procedural fairness” they were reluctant to suggest reablement unless it was obviously the most cost-efficient option. This meant that Northplace got a very small number of candidates for reablement. Compared to Southplace who had approximately 250 candidates over a two-year period, Northplace had only 30 candidates.

Thirdly, the different ways of organizing service in the two municipalities indirectly influenced to what extent and how the new service approach changed the mind-set of care staff. Although both municipalities had arrangements for practice based learning, the different number of candidates together with the different power structures of the service apparatus made up rather different learning context for care staff working in the conventional home care. In Southplace home care staff learned about reablement, through a peer observation scheme whereby care staff was regularly invited to shadow the team. Moreover, they learned from the follow up plans of candidate who had finished reablement , but continued with some help from the home care service and finally from regular meetings with the therapists from the reablement team who came to explore the possibilities for new candidates. In the interface between the reablement team and the home care groups learning was fostered by cross-service experiences. In Northplace the low number of candidates meant that care staff were not offered the opportunity they had hoped for to learn from practice. The Friday lunch reflection group run idle, as they had too few real life experience to discuss. However, the lunch group was redefined and became a highly valued opportunity for care staff to learn from the physio- and occupational therapists how they could work smarter in the conventional home care service.

MORE DISCUSSION: Learning context – expansive vs. restrictive

/ Idea translation the perceptual readiness of staff/

Some lessons:

- (1) Single initiatives may overlap and interact with adjacent initiatives, making separate analyses potentially misleading. (2) Local initiatives with similar labels (e.g., 'home care reablement') may be implemented by very different instruments and lead to different outcomes. (3) How particular interventions develop is often emergent – the path is made by walking, so to speak. (4) Emergent mechanisms may be either transformative or preservative, depending on contextual conditions.

Litterature (incomplete)

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