**Hogeschool van Arnhem en Nijmegen**

**Reablement: What does it mean?**

**A study regarding what reablement entails at various care- and wellbeing organizations in London, the United Kingdom.**

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**Practice-oriented research**

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# 

# INTRODUCTION

The aging of the population is a worldwide phenomenon. In 2015 there were around 901 million people worldwide aged 60 and over, representing 12.3% of the world's population. By 2030 this number will increase to 1.4 billion (16.4%) and by 2050 this will increase to 2.1 billion (21.3%) of the world's population (United Nations, Department of Economic and Social Affairs, Population Division, 2015).

Rijksinstituut voor Volksgezondheid en Milieu (2018) writes that the proportion of elderly people in the Dutch population is increasing as well. This means that aging will continue in the next 25 years. Not only is the population of the elderly growing, but people are also reaching older ages. There will be older elderly (85 years and older) due to the increase in life expectancy. In 2015 there were 3.1 million elderly people in the Netherlands, but by 2040 there are expected to be 4.8 million elderly people, an increase of almost 55%. In addition, there will also be more than 200 thousand more people aged 90 and over, which is a threefold increase in the number of this population in 2015. They also state that the aging population in the Netherlands poses many challenges for health care. In 2040 there will be an additional 1.2 million elderly people with multiple chronic conditions at the same time. What is more, Rijksinstituut states that in addition to chronic disorders, elderly people also often suffer from problems such as falling, memory problems, vision and hearing disorders, limitations in daily functioning, incontinence, loneliness and polypharmacy (the use of several medicines at the same time). Due to the aging population, more elderly people will suffer from these problems in the future. An accumulation of such problems increases the vulnerability of the elderly and also increases the complexity of the treatments. This puts more pressure on formal care.   
 In addition to the pressure on formal care, the pressure on informal care will increase as well due to the change in the number of possible informal caregivers. The possible group of informal caregivers, in this case, are the elderly between 50-64 years old, the children of the older elderly. The ratio will change over the next 25 years from one elderly in ten possible caregivers to one in four.

In the Netherlands, the health care system is currently defined in four laws: the Health Insurance Act, the Long-Term Care Act, the Social Support Act and the Youth Act (Rijksoverheid Ministerie van Volksgezondheid, Welzijn en Sport, 2016). The first three apply to the target group that emerges in this study. The Health Insurance Act is compulsory for every citizen and is regulated by health insurers, the government is not directly involved in the implementation, but it is involved in its completion. This law deals with curative care (the cure of diseases and ailments). People who require permanent supervision or need 24-hour care can claim the Long-Term Care Act. This is a national insurance policy based on solidarity. Everyone pays for this by paying taxes. Finally, the Social Care Act is focused on people with disabilities and is implemented by the borough (Rijksoverheid Ministerie van Volksgezondheid, Welzijn en Sport, 2016).

A similar trend was found in the elderly population in the UK. According to Office for National Statistics (2018), the percentage of older people in the UK will rise more slowly than in the Netherlands. In 2016 there were found 11.9 million elderly people in the UK. This is expected to rise to 17.7 million in 2041, which is an increase of around 48%. Within this group of older people, the group of older people will double from 1.6 million to 3.2 million. The UK now has a relatively higher number of elderly people in the Netherlands, but as shown in image 1, the Netherlands will far exceed the UK in 2035.

  
*Image 1: Percentage of people aged 65 and over, EU countries, 2015 and 2035 (shown).*

*Note:* Adapted from Living longer: how our population is changing and why it matters by Office for National Statistics. n.d. (https://www.ons.gov.uk). Copyright 2018, Office for National Statistics.

This trend of aging poses many challenges to health care. In the 1990s, new models were created in the United Kingdom (the UK) to meet these challenges, leaving room for "intermediate care" (Streiner, 1997; Parker & Peet, 2001). Intermediate care can be offered when someone is discharged from the hospital. Intermediate care is a means-tested, time-limited, short-term support. Professionals can offer this when there is room for improvement and more independence can be created with a client. It ensures that clients can live at home for longer, that they are prevented from being admitted to a care home or hospital and that when they return home a client becomes as independent as possible. This principle also includes a principle called *reablement* (AgeUK, 2019).

For many in the Netherlands, reablement is a not yet known term, but it has been used in the UK since the beginning of 2000 under various terms when using "intermediate care". Reablement is intensive support at home in the short term, with a focus on regaining or preventing the decline of "self-care skills" and social participation. In some countries, where a similar shift took place in the approach to delivering social care; some also called this new approach "reablement," while others, for example, the UK, Australia, and New Zealand, used the term "restorative care" (Social Care Institute For Excellence, 2013).

Reablement is offered in the UK by National Health Service (NHS). NHS has seven regional teams that support local healthcare systems. Every region, therefore, has its own organization of care, which falls under an NHS regional team (NHS, n.d.)

Assuming that reablement is an effective way of allowing elderly people to live independently at home for longer, it can, therefore, be said that it contributes to the independence of clients. Independency is important because it contributes to a better quality of life (Verhoef, 2013). Thanks to the goal-oriented approach, it provides an overview of the client and promotes independence by applying *self-care skills* again (Beresford, et al, 2019). The lack of knowledge about, and the inability to apply reablement, means that clients are more dependent on care. This also results in caregivers who have to come by several times a day, as opposed to applying reablement, where caregivers will reduce the frequency of care in a period of six weeks. If reablement is applied, the time of the caregiver can be distributed more efficiently, so that ultimately fewer costs are incurred, which is advantageous for the healthcare authority.

Since 2015, Dutch health care went through a transition from welfare state to participation society. More is expected from the elderly themselves and the environment of the elderly. "Everyone who is able to do so is asked to take responsibility for his or her own life and environment.". Rijksoverheid stated in 2013, which ultimately resulted in increased pressure on the caregiver. Veldheer, et al. (2012) has investigated that informal carers with a full-time job find the care of a parent to be light or strongly obstructive. Elderly people who are widowed move to care homes more quickly, because care at home can no longer be carried out to the same extent as when the partner was still alive (Verbeek-Oudijk & van Campen, 2017). These statistics show that, when the partner drops out, informal care changes from daily to weekly. This is due to the sudden change in the situation, which changes the composition and frequency of care. However, this does not cause dependence on care to change. Reablement, on the other hand, ensures that the dependence on care is reduced and that no major gap can arise between care needs and the care provided in unforeseen situations (Social Care Institute for Excellence, 2013).

Looking at the above assumptions, the implementation of reablement in the Dutch health care system might lead to new opportunities. To investigate how reablement can be applied in the Netherlands, it is important to first know what reablement entails and what the experiences are of healthcare professionals who are familiar with this method. As a result, it might be possible to make a statement about the application possibilities in Dutch health and social care.

# RESEARCH DEFINITION

***Problem description***

To investigate how reablement can be applied in the Netherlands, it is important to first know what reablement entails in health and welfare and what the experiences are of healthcare professionals who are familiar with this method. The problem is, therefore: “It is not known in the Netherlands what reablement entails in health and welfare and what the experiences of healthcare professionals that are familiar with this concept are. As a result, it is also not known whether reablement has added value in the Dutch context."

***Objective***

Once it is known what reablement entails and what the experiences of healthcare professionals that are familiar with this concept are, a statement can be made whether reablement has added value in the Dutch health and social care.

Investigate what reablement entails within various organizations of health and well-being.

1. Investigate the experiences of health professionals within various UK reablement teams.
2. Formulate a statement about the application of reablement in Dutch health and social care.

# METHOD

## Research design

A qualitative study has been chosen. This research is about the knowledge of the subject, gained through the eyes of another. The data is collected by semi-structured face-to-face interviews and is then analyzed in an iterative process. Triangulation, a pilot interview, and a member check are the strategies that have been used to increase the validity and usability of the results.

## Ethics

In order to prevent harm to the interests of the organization and the participants, the following steps based on guidelines of ethics were set up (van der Donk, 2019, p. 74.75):

* The student researchers discussed with the supervisor and the client what was being investigated. Limits were set, plans and intentions were discussed fairly and reports were made when there are changes.
* Participants were asked for permission and were informed as fully as possible. Informed consent was signed by the participants. This states which research is involved and what the participant gives permission for.
* After the conducted interviews it will not be traceable which participant told what information. The participants had been assigned a non-traceable code. These codes were also applied when appointing persons in an interview. This is to guarantee quality in accordance with Algemene Verordening Gegevensbescherming, also known as AVG (Autoriteit Persoonsgegevens, 2019).
* Collected data had been carefully stored and remained in the possession of the student researchers.
* By means of a member check after the interviews, the processed data has been checked again with the participants.
* The participants were informed in advance about the publication of this article in the school setting and as part of their examination.

## 

## Participants

* Recruitment

The research was dependent on the response obtained from the professional field. The first contact in London was an alumnus from the HAN who was recruited by the client. Additional participants were recruited by the snowball method. Each participant was asked to come forward with suggestions for further recruitment.

Participants who were willing to participate in the study on the basis of the disseminated information registered with the research group by telephone or email. At registration, the potential participant has been emailed back via an email designed for this occasion. The email explained the process that would be followed when participating in the research project. In the email, the participant was given the choice of whether or not to participate.

* Selection criteria

The student researchers were responsible for the recruitment and selection of participants. This meant that the student researchers made a selection of participants based on the inclusion and exclusion criteria established beforehand. To define the target group, the following inclusion and exclusion criteria are described in table 1.

Table 1: *Inclusion and exclusion criteria for the participants.*

|  |  |
| --- | --- |
| **Inclusion criteria** | **Exclusion criteria** |
| The participant has at least half a year of experience working with reablement. | The participant is not a healthcare professional who has experience with working with reablement. |
| The participant is at work in one of the London boroughs. | The participant is not a resident of London, United Kingdom. |
| The participant is 18 years or older and competent. |  |

It was stated at the start of the study that at least four participants should be included.

In the end, four participants were recruited and willing to be interviewed. The information of the participants is included in table 2.

Table 2: *Information about the participants.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Education** | **Function** | **Background in healthcare** | **Years of experience in reablement** | **Borough** |
| **R1** | Occupational therapist | Occupational therapist | Has worked as an OT in an intermediate care team, before this team was transformed in a reablement team. | 18 years of experience as an OT of which six in the reablement team. | Kingston |
| **R2** | Occupational therapist | Occupational therapist | Has worked as an OT in Australia, in an elderly rehab setting. | 28 years of experience as an OT, of which 16 years in the intermediate care team (which is now transformed into the reablement team). | Teddington |
| **R3** | **\*** | Case manager | Former carer in reablement. | Nine years of experience with reablement. | Islington |
| **R4** | Occupational therapist | Case manager | Has experience as an occupational therapist in an acute hospital. | Nine months experience in the reablement team. | Morton |

\* = unknown

* Location

The interviews were conducted in a location chosen by the participant. This was chosen so that it became as easy as possible for the participant to participate. The locations were often in their work environment and scheduled between meetings and treatments.

## Data collection

The main purpose of this research is to find a description (Oost & Markenhof, 2016), Therefore semi-structured interviews were conducted (Van der Donk & Van Lanen (2016). In this type of interview, the important topics will be discussed, and the possibility is given to the participants to give their own interpretation. By opting for a semi-structured interview, there is a possibility to keep asking questions about ambiguities and interesting aspects, so that more specific information can be collected. This is essential for this research (Van der Donk & Van Lanen, 2016). During the interview, an interview guide is used (see Appendix 1: interview guide), which was drawn up on the basis of Spierings (2013) and in collaboration with the client. After conducting a pilot interview, the interview guide was adjusted.

Individual interviews were chosen so that the schedule of the healthcare professional could be taken into account. An individual interview also ensures that the subject can be discussed in-depth and the participant is not inhibited in his or her expressions (Baarda, 2018).

When documents that are being used in the reablement service are provided by participants during the interview, their use is estimated to be of value. The data collected from the received documents are included in the analysis of the findings. Documents are non-reactive, which is an advantage for the quality assurance of this research. They are produced for their own purposes and not for research, which causes the quality of the documents to increase (Reulink & Lindeman, 2005).

## Roles and styles

Both the student researchers are present during the interview. The roles of the student researchers differ from each other. One student researcher asks the questions, while the other student researcher observes and provides additions.

## Data analysis

Sound recordings are made during the interviews. The reason for this is that the interviews are transcribed. The participants have given permission for the sound recordings, based on written and verbal participant information. The informed consent has been signed for this.

The interviews are transcribed in a denaturalized way, this is a method that is used when there is a focus on the content of an interview (Oliver, Serovich & Mason, 2005). After transcribing the interviews, the themes were set based on the chosen analysis methods.

Both inductive and deductive analysing methods were used to analyse the interviews. A framework has been made for the interviews through research and conversations with professionals who did not meet the inclusion criteria. This basic structure means that the information could be meaningfully compared by using a deductive analysis method. By adding an inductive analysis any unforeseeable documents or comments are able to be added to the findings.

# FINDINGS

Three themes were identified in the analysis:

(1) The art of reablement, (2) Personalised care and (3) It’s all about communication and expectation (Table 3). Each of these themes and related subthemes are described in detail with quotes to illustrate the themes.

Table 3: *Themes and subthemes identified through analysis of the conducted interviews.*

|  |  |
| --- | --- |
| **The art of reablement** | * Formation of the team * Roles and tasks * Up to six weeks and covered by the NHS and local council * Baseline * Social contacts * Increase independence * Decrease package of care and reduce healthcare costs * Shared decision making |
| **Personalised care** | * Clients * Demographics * Referrals * Feeling entitled to 6 weeks of care |
| **It’s all about communication and expectation** | * Communication between hospital and reablement team * Communication between carers of other agencies and reablement team * Expectations |

### 

### The art of reablement

**→ Formation of the team**

A reablement team almost always consists of carers, occupational therapists, physios and social workers. Sometimes some other professionals are added to the team, like dieticians, nurses or pharmacists. It is not known why the teams are composed the way they are. In the following image, it is shown how a reablement team could be composed.

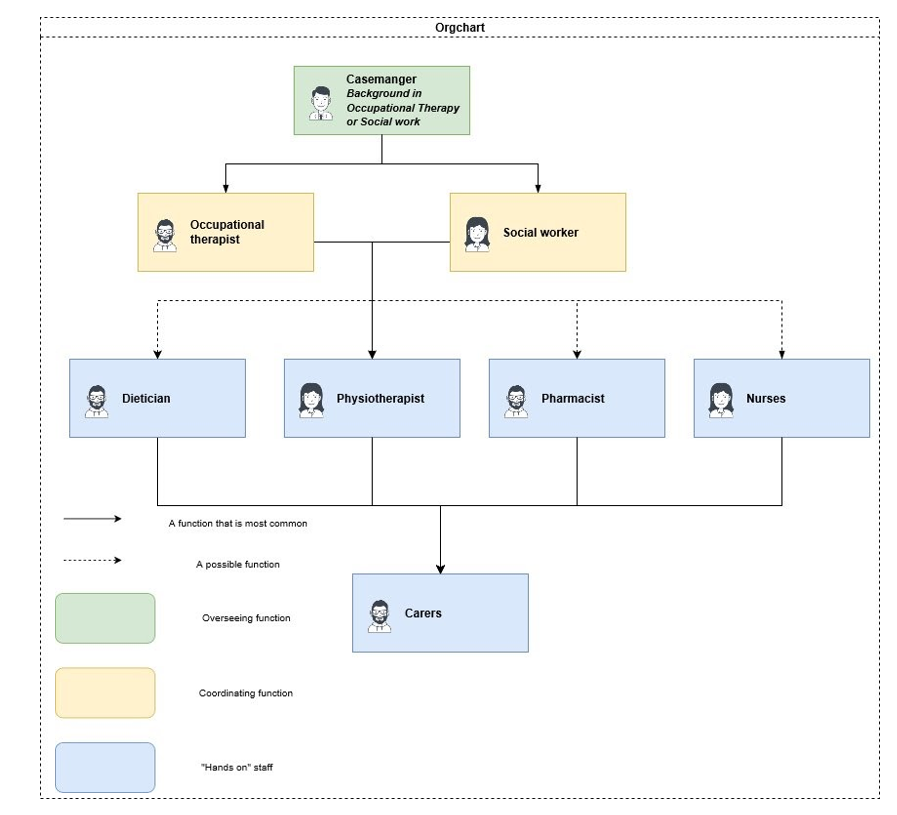


Image 2: *Organizational chart of what a reablement team could look like based on the outcome of the interviews.*

*“A part-time dietitian, we’ve[the reablement team] got social workers... We’ve got physios, we’ve got nurses and OTs and therapy assistants. And then we have also the inhouse rehab assistants.” [R1]*

*“We have occupational therapist, physiotherapist, social worker and I think pharmacist.” [R3]*

→ **Roles and tasks**

Many roles overlap in the reablement team. A lot of tasks can be executed by many different professionals. Although this causes confusion, it mainly ensures that work can be done more efficiently because there is no need to call in another professional first.

*“We[reablement team] have something called a skillshare day, where we all get together and… [ professionals share certain skills to decrease the number of calls.] … It empowers you as well, because it means that you can kind of manage. You feel competent to manage what you need to.” [R2]*

**→ Up to 6 weeks covered by the NHS and local council**

Reablement is a service provided by the local council. Every borough has its own team and works in a different way. Reablement is a free service for everyone in the UK that can be provided for up to six weeks. This does not mean that every client that goes into reablement uses the service for six weeks.

*“The reablement is jointly sponsored by the hospital and the local authority.” [R3]*

*“So we can provide reablement support for up to six weeks” [R2]*

**→ Baseline**

Reablement is a service that helps people to get back to their baseline after their discharge from a hospital. Baseline is simply whatever they need to live at home independently. Sometimes, a checklist is used to select the goals [Appendix 2]. This checklist was provided by a participant during the interview.

*“The main goals in reablement revolve around mobility inhouse and outhouse, selfcare and meal preparation.” [Appendix 2]*

*“So they [patient] need to have goals. They [patient] need to have identified goals around personal care, meal preparation, mobility. Getting out and about, just all of the ADL kind of activities. And achievable within our timeframe.”[R2]*

*“So mostly the reablement comes from the hospital was there well enough to be discharged but that man might just need extra help to get him back to that baseline.” [R3]*

**→ Social contacts**

Next of kin are asked to support clients in the initial assessment. In the reablement service, social contacts like friends or family are used only when they are already supporting the client in their daily activities. The reablement service is not dependent on social contacts to take on the role as a carer. This means that the social contacts are used to support clients in their treatment, but not as a solution.

*“We try not to use them [family] as a carer unless they're for that to be their role.” [R2]*

*“Oh yeah! So using them in terms of practice, reinforcing what we’ve said, supervising exercises, you know, working towards goals.” [R1]*

**→ Increase independence**

The main focus of reablement is to increase the independence of the clients, for them to be able to live at home for as long as possible. All of the goals are focussed around the potential that a client has and making use of those to increase independence. It’s all about what a client can do and empowering them to work on what they cannot do.

*“So I always think of reablement of trying to encourage independence. So trying to get someone as independent as possible, to maximize their independence in their own daily activities.” [R2]*

*The nature of the service is about maximizing people's potential. Giving them a chance and empowering, and empowering gives them choices. [R4]*

**→ Decrease the package of care and to reduce healthcare costs**

By using reablement you’re able to assess someone’s needs in care. It also makes it possible to quickly determine what someone can and cannot do. With this approach, goals are set together with the client that the reablement team will work on. These goals are set in such a way that ultimately a reduction in dependence on care is achieved. This is shown in a reduction in the intensity and in the frequency of care.

*“And to just view things differently and it may not be in that purist sense of what’s their [the client] goal and it may be, how can we reduce their package of care, and reduce the financial burden on this person and therefore improving their quality of life.” [R1]*

*“So deciding how much help is necessary, instead of putting a package of care to the maximum, reablement treatment is a good way to assess exactly what the person needs is an assessment pathway.” [R4]*

**→ Shared decision making**

During the process, there is not always room for the client to choose what they want to do. It sometimes happens that a client ends up in the reablement service, but really does not want to. The hospital puts too much pressure on the use of reablement in order to speed up discharge.

Once in the service, on the other hand, it is checked what the client wants. With the initial assessment, someone can leave the service immediately again when they want to. The risk is of course checked and noted, but they cannot force someone to stay within the service. If the client does want to stay in the service, the client and the professional who does the initial assessment will look at what they can and cannot do. Goals are set from this perspective.

“*I am aware of my reablement goals and plan which has been discussed and agreed with me.*” [Appendix 3]

*" I'm going to him [the client] yesterday and he said he doesn't want the service. So I said to him: "Why do you come in here?". He [the client] said: "They [the hospital] wanted me to have it."." [R3]*

*“ Go in with their consent, test them and try and formulate goals with them as to what they would like to improve their independence with.” [R1]*

### Personalised care

Reablement is a service provided for people who have been discharged from the hospital and is 18 years and over. It is also required that they have the potential to improve. They need to be cognitively well enough to retain information. Even though everyone is entitled to reablement, it is estimated that 90% of the clients are 60+. Clients can come through hospital discharge or by community referrals. Community referrals often come from other professionals in the borough, the next of kin or other people in the clients’ social network. This mostly happens when people are deteriorating at home.

**→ Clients**

A lot of clients within the reablement service are aged over 65. Falls is a big problem in the age group over 80. A lot of the reablement service is revolved around falls and prevention of falls.

*“Most of, I’d say 90 percent is in their 70 plus.” [R4]*

*“So it's very much around education on looking after themselves [clients] and prevention of falls and prevention of complications if they do fall.” [R2]*

It is also required that clients have the potential to improve. They need to be cognitively well enough to retain information.

*“So they [client] need to be able to participate in rehab. So they [client] need to be, cognitively be able to understand and process information that's given to them. And follow, kind of, basic step instructions.”[R2]*

*“That they have rehab potential. That they’re able to retain information and progress basically.” [R1]*

**→ Demographics**

In areas of deprivation, people are earlier dependent on reablement service. This can be seen in prosperity areas, where life expectancy is higher than the areas of deprivation. The deprivation comes from a lack of higher education and not enough money to spend on a healthy lifestyle.

*“Obviously we’ve got areas of deprivation where that is turned on its head, and you can have 60 year olds who are less good as some of the affluent 90 year olds which is really sad.”[R1]*

*“ So because people in Wimbledon are financially more stable, they make more money, they live longer than people in poorer areas. So we had a lot of our very elderly people coming to reablement.”[R4]*

The elderly from the 1940s are less likely to use the reablement service. The generations that come after that are more likely to use the service. This is because early generations grew up with a different healthcare system and very much about solving their own problems.

*“Because I’m talking the people that have been through kind of the First World War type of thing. Where they didn’t have NHS, they didn’t have a safe Social Care system, they are very stoic, they’re very independent and real problem solvers. And they do not ask the state for help... I think that with the generation, certainly from England’s point of view, that are coming through are more dependent on the state.” [R1]*

*→* **Referrals**

Clients can come through hospital discharge or by community referrals. Community referrals often come from other professionals in the borough, the next of kin or other people in the clients’ social network.

*“Richmond access team often contacts us: "we've had a phone call, this person's not well at home. … Could you go out and see them?" We will then pick up.” [R2]*

*“So we have a referral from the house so we accept referrals from the hospital directly. Then we also accept community referrals.” [R4]*

Even though referrals can come through from the community, there is a lack of care within social contexts and the use of informal care. Using the community to make sure people are not deteriorating at home could lead to earlier referrals from the community.

*“I’d like to see more community kind of… I think that we’ve lost some of that... Some of what used to support people.” [R1]*

**→ The feeling of being entitled to the six weeks of care**

It sometimes occurs that clients become dependent on 6 weeks of care. They stick to it, not only because they think they need it, but also because they do not want to pay for the additional care after reablement. Reablement is a service that does not necessarily have to last 6 weeks.

*“They [clients] don't pay for the support, so they cling on to the six weeks of care.” [R2]*

*“So they [the clients] get upset because ... they need to pay, because district nurse is not free of charge... So people are not happy about it.” [R4]*

### 

### It’s all about communication and expectation

**→ Communication between hospital and reablement team.**

The communication between the hospital and the reablement team can be difficult at times. For example, clients are put into the service, that do not have to enter the service at all. This happens because the hospital or the local council wants everyone - take the assessment - to reduce healthcare. The hospital also does not always know what the reablement team needs for its interventions and vice versa. This results in decreased efficiency in their work. A lot of time is lost on obtaining all the correct information referred to the reablement service.

*“Sometimes from a hospital point of view, they feel that we're trying to prevent discharge sometimes rather than facilitate discharge.” [R2]*

*“We’re going to let you know this person is in hospital and we communicate over the period of time until, say we’ll be asking for a therapy report in that instance.” [R1]*

Not only is there a gap in the communication about the referrals, but there is also a lot of pressure on the hospital discharge because of the limited beds in the hospital. Whenever a discharge is being called through to reablement, it is mandatory for the team to accept them.

*“They basically, because there is so much pressure on hospital discharge, they [management] want us to basically accept anything that comes through the door, which has its pros and cons. Obviously, it releases the hospitals to accept more referrals but sometimes it blocks our reablement provision as far as the care side of things goes.” [R2]*

*“That's different because we are under a lot of pressure to discharge from the hospitals. As soon as a hospital give a red alert they need to have beds. This means we need to take everyone.” [R4]*

**→ Communication between carers from other agencies**It can occur that the carers are being brought in through another agency, they are located in another building. This means that they don’t know each other and are not able to communicate directly with each other. Any inconsistencies at work, different work methods or issues are not directly communicated to the person responsible. Because there is a lot of time spent on resolving any misunderstandings there could be a loss of time management.

*“But these people [the carers], they have their own contracts with their own companies, and they’re asked to do this work on our behalf but they report to their own, their own managers etc. And so there is the problem, it goes to their manager, and it relies on their manager coming to us [the reablement team], and getting to us and telling us that there is an issue.” [R1]*

**→ Expectations**

Because there are certain expectations on the use of the service from the hospital or local council, it puts a lot of pressure on the professionals in the team and it increases the workload. It takes a lot of time to assess clients that are clearly not eligible for reablement but need a longer-term package of care. It is expected that the reablement determines what kind of package of care they need. This causes a loss of time spent on people that actually need the service.

*“Like this a start-up assessment, yes. So that's the reablement here in Morton is used on say 60 percent of the time as an assessment.**Halfway, for a long term care package.” [R4]*

*“When I get a referral and I go through I'll say: "This is not reablement." Some you can tell. "This is not reablement." They [the hospital] can just arrange long term support from the hospital, rather than bringing them here [the reablement team].” [R3]*

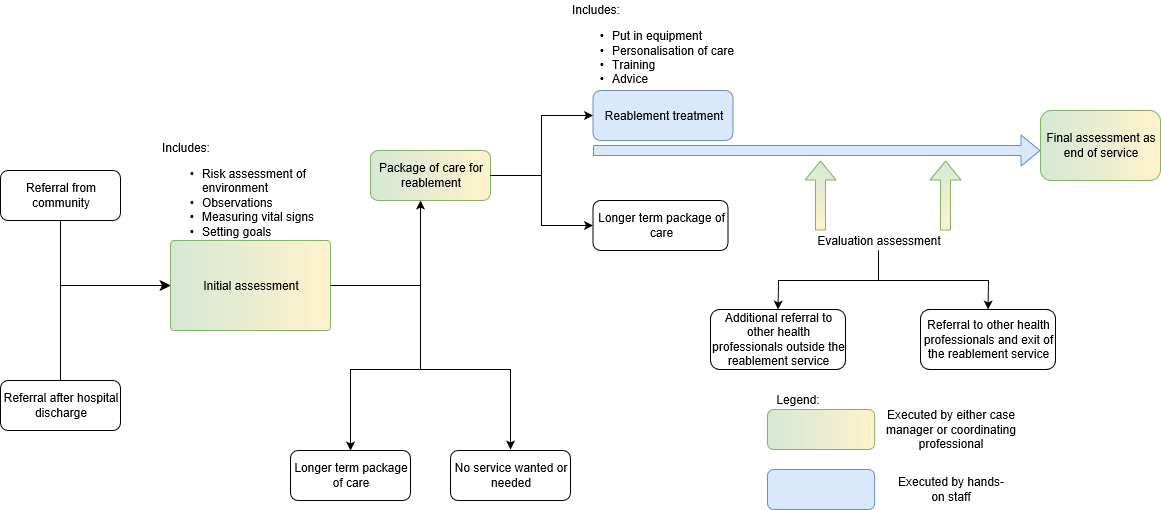
# DISCUSSION

## Entailment of reablement

This study explored the meaning of reablement by interviewing four health professionals actually working in a reablement team in different boroughs of London. The interviews and documents provided by the participants revealed that reablement is a service provided by the National Health Service (NHS) and the local council. Reablement is mostly used by elderly people but is available for anyone over 18 to increase independence.

This service is provided up to six weeks and either helps people get back to baseline or provide the correct package of care. Goals around getting back to baseline are mostly focussed around help with meal preparation, self-care and mobility inhouse and outhouse. Sometimes the service revolves around making sure the client stays at baseline, by putting effort into the prevention of deterioration. To achieve those goals a reablement team might provide equipment, training or advice. By using reablement healthcare costs are reduced, by pushing back the use of care and personalizing care.

In the image below it is shown what options there are in a reablement service.

Image 3: *Possible routes in a reablement service.*

No attention is paid to leisure activities, resuming work or resuming other roles such as being a grandparent or girlfriend. The service does not focus on all activities of daily life. It is about the minimum to maintain at home.

Communication and expectations are big aspects that influence reablement. It can occur that clients have the idea that they are entitled to 6 weeks of care and really cling on to it. This happens because the service is free i.e. paid by NHS and the local council and some clients do not always want to pay for care. For a reablement employee, this is a difficult issue to deal with.

The communication also influences who enters the service. After discharge from the hospital, many people enter the reablement service, where they do not always belong. This is due to the great pressure on the discharge of clients from the hospital. The fact that the client does not always have a say in whether or not they come into service is also a factor. Both aspects ensure that the pressure on the service is increased and that efficiency decreases.

During the interviews, the student researchers noticed a lot of similarities between reablement and the core values of occupational therapy in the Netherlands. Van Hartingsveldt, Logister-Proost and Kinébanian (2010, p. 15) define occupational therapy as enabling occupation to increase participation in day-to-day life to promote health and wellbeing. This is achieved through utilizing and increasing the possibilities of the person in relation to occupation and/or through adapting and using the environment.

As shown in the findings, reablement in the UK can be defined as a method to increase health and wellbeing through the temporary use of care. All of the goals are focussed around the potential that a client has and making use of those to increase independence. It’s all about what a client can do and empowering them to work on what they cannot do. To achieve their goals a reablement team might provide equipment, training or advice. These relate to the adapting and the use of the environment stated in the definition of occupation therapy earlier.

Comparing these two definitions, one might say the methods are very much alike. Both use interventions and empowerment as a tool to increase the independence of the client. Through realistic goal setting the time spent with the service can be efficiently used. The definition of health by Huber et al. (2011) applies to both methods. Huber defined health as “the ability to adapt and to self-manage, in the face of social, physical and emotional challenges”. Health is not about being healthy anymore, it is about coping autonomously with life’s challenges. Both occupational therapy and reablement is all about maximizing the role of human capacity.

## Importance and implementation in the Netherlands

Over the next 25 years, there will be a growth of 55% in the older generation (65+) in the Netherlands (Rijksinstituut voor Volksgezondheid en Milieu, 2018). This growing group of elderly people will suffer from multimorbidity as well as other problems such as falls, memory loss, vision and hearing problems and limitations in daily functioning, incontinence, loneliness, and polypharmacy. All these problems increase the pressure on formal care, as the treatments are becoming increasingly complex. The pressure on informal care is growing as well due to the shift in the ratio of possible caregivers for the elderly from one in ten to one in four in the next 25 years.

In addition to a shift in the ratio of informal caregivers, there is also a shift in the ratio of district nursing. According to Vilans (2018), around 8.800 HBO district nurses worked in district nursing in 2015, a deficit of 4%. It is expected that between 10.000 and 13.500 district nurses will be needed in 2019 (an increase of 8% - 45% compared to 2015). Due to the shortage of informal care, informal carers are not able to ask for professional help when they need to. This also increases the pressure on informal caregivers.

To make sure that the lack of carers will not increase, it is important to decrease the pressure on both types of care.

The use of reablement as an initial assessment is widely used in the UK. As a result, the influx of clients is controlled and the intention is to keep control of the correct deployment of the package of care. Part of the care can also be reduced with this.

If reablement would be applied in the Dutch context, the student researches would advocate for the use of the initial assessment to local councils. Because the influx of clients is not controlled in the Netherlands, there is a chance that care is not efficiently used or put in place. Using the initial assessment would control who needs what in their package of care and therefore reducing the professionals needed. This could also decrease the workload of both informal and formal carers.

In the UK, formal care is mainly used for treatment in reablement. Informal care, such as family, acquaintances, neighbours or other social contacts, is used in a different and less intensive way than in the Netherlands. As the findings show, in the UK the environment is not expected to take on a role as a carer whereas this is actively done in the Netherlands. Both options do not seem to be the ultimate solution to the ever-increasing problem. Regarding whether or not the social network is deployed, the UK and NL are at two extremes of a spectrum alongside formal care and there are still many opportunities for both countries. In addition to advocating for the use of the initial assessment, the student researchers would advocate for the use of reablement in the Netherlands. However, reablement would only be successful in the Netherlands if the social context is used in a way that is not harmful to the formal and informal care like it is now.

To apply the use of social contacts, the student researchers would advise the use of Community Based Rehabilitation (CBR). In the Netherlands, the use of CBR is an emerging phenomenon. CBR focuses on three aspects: physical, mental and social. Implementation of CBR takes place through the joint effort of people with disabilities, their families and communities and relevant facilities in the areas of health care, education, vocational training, and social affairs (WHO, 2004). When using CBR, the focus is therefore not on immediately increasing the package of care, but initially looking at what is already being offered in the community. This varies from prevention and personal support to the use of more general facilities. (le Granse, van Hartingsveldt, & Kinébanian, 2017, p. 75). In addition, a new resource is created that can be used during treatment.

It has been proven that social involvement with frail older people means that local care is less likely to be called upon (visit to a doctor or household help) (Bath & Gardiner, 2005). By using the social context, people will initially look for help in their community, before contacting a doctor or carer. This results in clients being more independent and less dependent on formal care as well as the burden of informal care being carried out by more people.

## Strengths and limitations of the research

A strength of the research was using both literature on reablement and personal experiences of the professionals in data collection and analysing the collected data. The validation and the quality of the research increased because of not limiting their research to one aspect of a definition.

The interviews that were conducted were very profound. By combining the collected data from the interviews, the student researchers were able to answer the main goal of the research. By adding literature, the student researchers were able to add another meaningful layer to the information. And thus, being able to make a comparison between two completely different contexts (the UK and the Netherlands).

Because the student researchers were living in London for three months, they were able to talk to various health professionals outside of reablement. This way they were able to understand the UK context and the culture and how it affects reablement.

A number of limitations were encountered in the research. These limitations have had an effect on reliability and outcomes. Firstly, there have been problems with privacy legislation. Because two different laws had to be taken into account, it was very difficult to find an optimal solution. This also made it more difficult to recruit professionals for the research, because there is strict legislation on conducting research in England. For conducting an official interview, ethical permission would have been applied for. As a result, not many participants were recruited, which had an impact on the number of results. Although the interviews were very thorough, the research would have been more reliable if more people from different professions and from different boroughs were interviewed. This would also contribute to the validity of the research.

During the analysis of the data, it became clear that the student researchers did not always consistently ask questions. This concerned in particular the why questions. For example, the participants talked about the composition of a team, but afterward, there was no question as to why a team was composed in this way. The researchers wanted to consistently ask the why question. The pilot interview did not reveal that more attention had to be paid to the questioning, in retrospect that should have been the case.

Moreover, the focus of this research is only on London itself. It would be a nice addition if it was drawn wider than just London. There were already so many differences between the different boroughs that it can be suggested that there are also differences within the UK. There are also several countries that implement reablement as mentioned in the introduction of this research, so a next step could be made by examining their implementation.

## Future research

The student researchers are of the opinion that follow-up research still needs to be carried out to implement reablement in the Dutch setting. For the use of this service and CBR as an addition, they propose to investigate the effect of CBR on the rehabilitation process in the Netherlands. To what extent is it now being used and what ensures efficient implementation. This research might show how this results in social engagement and whether it leads to a real reduction in the demand for formal care.

In addition, the student researchers are curious about the use of the community in the English context. Extra research could clear up how the community is used there or what the points for improvement are. From this research, it can be investigated whether CBR or a version thereof, can be applied in England.

# CONCLUSION

This study explored the meaning of reablement by interviewing four health professionals actually working in a reablement team in different boroughs of London. The interviews and documents provided by the participants revealed that reablement is a service provided by the National Health Service (NHS) and the local council. Reablement is mostly used by elderly people but is available for anyone over 18 to increase independence.

This service is provided up to six weeks and either helps people get back to baseline or provide the correct package of care. Goals around getting back to baseline are mostly focussed around help with meal preparation, self-care and mobility inhouse and outhouse. Sometimes the service revolves around making sure the client stays at baseline, by putting effort into the prevention of deterioration. To achieve those goals a reablement team might provide equipment, training or advice. By using reablement healthcare costs are reduced, by pushing back the use of care and personalizing care. As shown in figure 3, reablement has many different options a client can take before or during the service.

There are parts of reablement that would be an addition to the Dutch healthcare system.

The student researchers would advise the local councils to use the initial assessment that reablement has, therefore controlling the influx of clients. The second advice would be to implement reablement but to add and use the social context in such a way that is not harmful to informal care.

A way to harm the informal carers less and to reduce the pressure on formal care as well as the use of CBR. CBR is already applied in the Netherlands. Combining CBR with reablement, another resource is added to the treatment.

For the client, this means that there are possibilities before the doctor is called in. With the option to first reach out to the community, the clients will feel more independent and less dependent on formal care as well as the burden of informal care being carried out by more people.

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# APPENDIX 1: INTERVIEW GUIDE REABLEMENT

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| --- |
| **INTRODUCTION** |

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| --- | --- |
| **Introduction** | Introducing + handing over the informed consent  First of all, thank you so much for agreeing to meet us and discuss reablement. Hopefully, you have had a chance to read the information letter we emailed to you? We have just given you the informed consent, which we also sent to you over email, stating what we will do with the obtained information. Do you have any questions about any of the documents? |
| **Goal of this project** | With this interview, you are one of the health professionals agreeing to help us with our project. We will be talking to different health professionals who are located in London but are working in different boroughs. With this project, we want to create an image of what reablement is and how it is executed. Your story and opinions are important for our project about reablement, so please feel free to add anything you find useful. |
| **Subjects** | These are the subjects we would like to talk about during this interview:   * Execution of reablement in your borough * Patient groups/demographics of the people you see * Personal experience * Influential factors |
| **Anonymity and confidentiality** | Before we start this interview we would like you to read and sign the informed consent. Like we said before, in this agreement it states what we will do with the information we gather from these interviews and how we will maintain your anonymity. Everything you say is confidential, and if you don’t want to answer questions that is perfectly okay. |
| **Early termination** | If you wish to stop at any point in the interview, just let us know. We will stop the interview. |
| **Recording** | As you can read in the informed consent, we will be recording this conversation.  Because we will be following the Dutch law regarding privacy, we are allowed to record this conversation, as long as there is permission granted from the interviewed. |
| **Roles** | I will be doing the interview and my companion will be taking notes. |
| **Questions** | Different questions:  How-questions: says something about experiences, approach or action;  What-questions: says something about the content;  Why-questions: requires accountability;  Which questions: says something about type and type;  Who-questions: says something about people; |

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| **VARIABLES, TOPICS, CENTRAL QUESTIONS AND SUBQUESTIONS** |

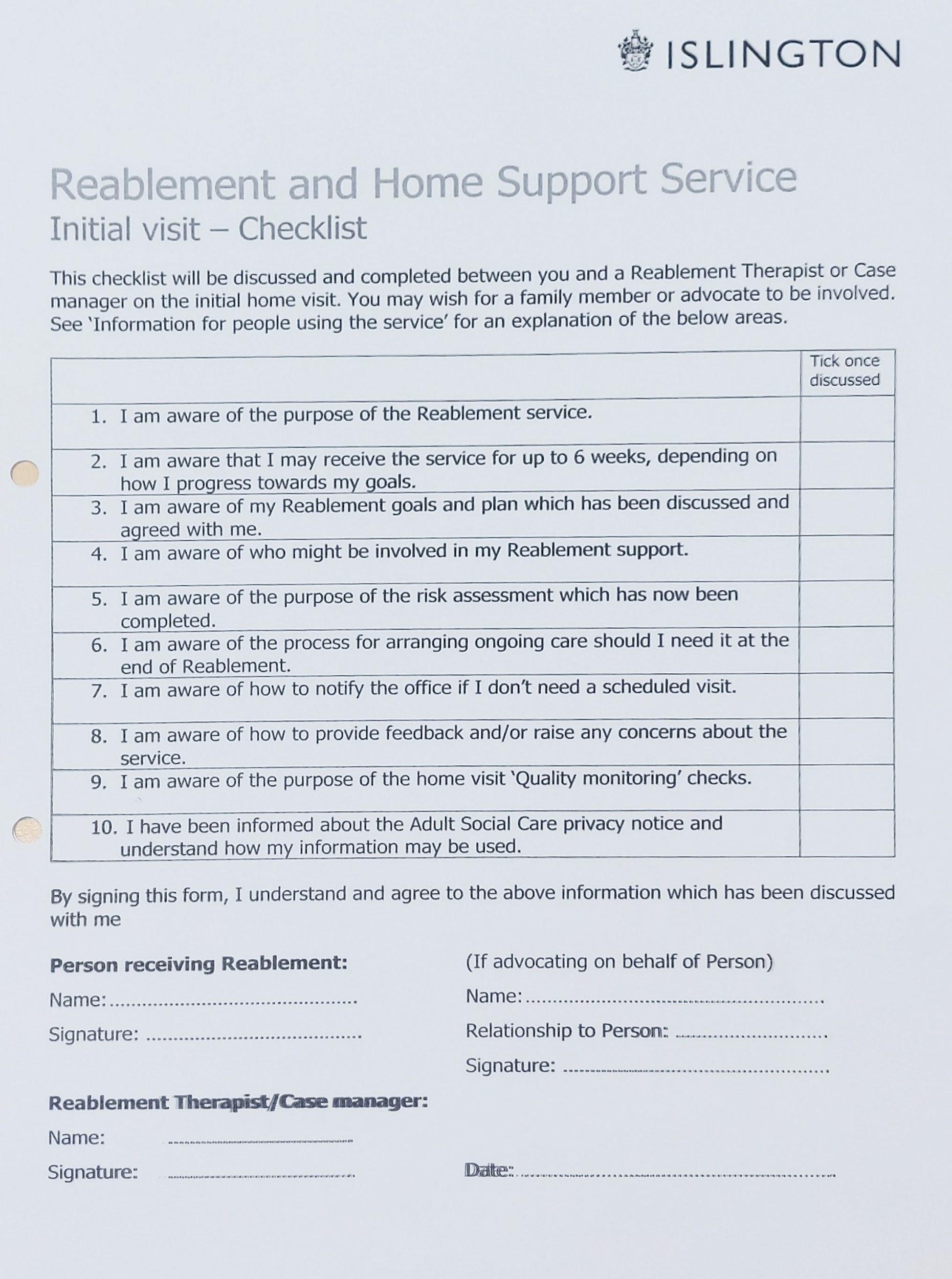
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| --- | --- |
| **General**  Topics:   * Age, gender * Years of work experience * Place of work * Previous experience | We will firstly start with who you are, so could you tell us a little about yourself?  How long have you worked with reablement?  What type of professionals does your team consist of?  How many people work in your team?  Do you have any previous experience working in healthcare? |
| **Execution of reablement in the borough**  Topics:   * Procedure * Dynamics of the team * Roles within the team | So, how is reablement executed in your place of work? What would be the first step in a reablement treatment?  How do you determine which professionals they will see?  What are the differences between the tasks of the professionals in your team?  Do their roles or tasks ever overlap with other professionals?  Are there multiple reablement teams in your borough?  Do you know how reablement is executed throughout the entire borough? (Same or different?)  Because you work with a certain timeframe, do you feel that it affects your process?  What makes someone eligible for reablement?  Are there certain exclusion criteria?  Are there other treatments (inpatient or outpatiënt) in your borough? Or just reablement?  When would someone be eligible for home rehabilitation or hospital rehabilitation?  How would you use social contacts like family or friends of a patiënt in your treatment?  Could you give us an example? |
| **Patiëntgroups / demographics**  Topics:   * Age * Social status * Diagnosis * Goal | How would you classify the people who are eligible for reablement, are there a lot of similarities or do they differ a lot? If so how are they different or the same?  What age is most common to work with?  Is there a specific demographic aspect that you see generally? Examples could be, education level, income level, occupation, religion.  Do they affect the way you provide this service?  What diagnosis do you see most in your workdays?  We know that with reablement, the clients work with goals. What kind of goals do the patiënts usually have? |
| **Personal experience**  Topics:   * General image * Practicality | What do you think other countries could learn from reablement?  What do you think are aspects of reablement that could still be improved?  What do you know about literature focussing on reablement?  Do you think that how the Care Act describes reablement and the reality are similar or completely different? If so, why do you think that is?  The Care Act also describes home-based rehabilitation, could you describe what differs reablement from that?  What could other boroughs learn about how reablement is implemented in your reablement team?  What are the ways to improve how reablement is executed in your borough? |
| **Influential factors**  Topics:   * Financial pros and cons * Therapeutic aspect * Institutional aspect * Governmental aspect | Do you know a little about the governmental view of reablement?  What are things that the government does or provides that are beneficial to reablement?  On the other hand, what are things the government could do to improve the way reablement is executed?  What are things that your team does that you wouldn’t change in the execution of reablement?  What are things that your team can improve on in the execution?  Do you think reablement is an addition to a client’s rehabilitation plan, or are there other ways someone could be stimulated or empowered? Both physically and mentally?  Could you give us an example of a case where reablement had an impact on the quality of life of a patient?  How would you describe reablement to someone who has never heard of the term? |

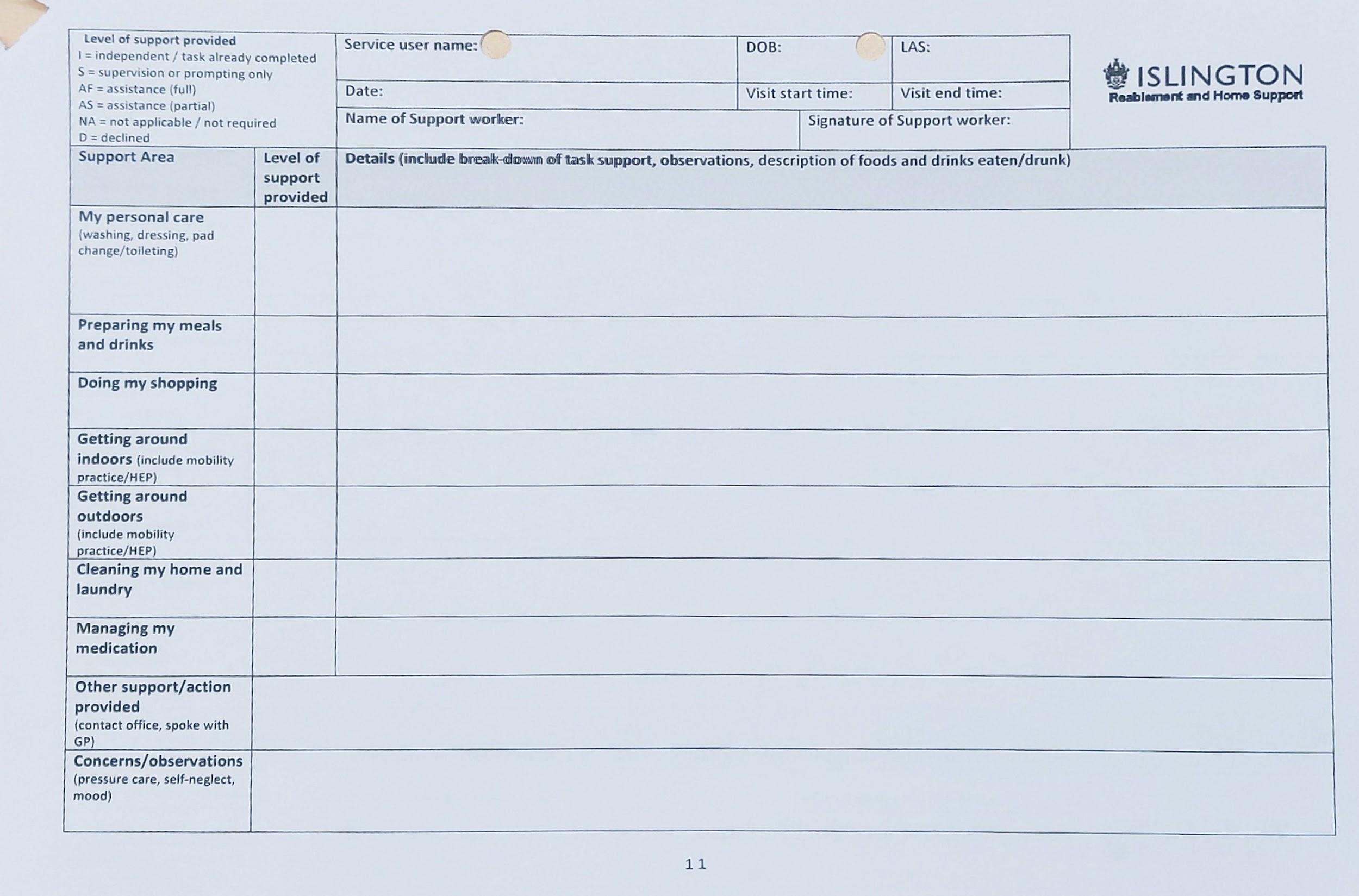
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| **CLOSING** |

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| --- | --- |
| **Closing interview** | We have come to the end of our questions, do you have anything else to add?  Are there things that we haven’t mentioned in the interview that you find useful to tell us?  What did you think about the interview? |
| **Member checking** | The interview will be written out. Would you like to receive a summary of the final transcript to approve? |
| **Thanking for the interview** | We would like to thank you for your time and participation! We really hope that you have felt that you were able to tell your story and that we listened to you. |
| **Leaving our contact information** | If you have any questions or anything else you want to add, please feel free to contact us by sending an email to project.reablement@gmail.com. |

# APPENDIX 2: CHECKLIST GOALS

# APPENDIX 3: INITIAL VISIT CHECKLIST





# APPENDIX 3 : INITIAL VISIT CHECKLIST

