



Factors Impacting User Engagement in Reablement: A Qualitative Study of User, Family Member and Practitioners' Views

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Background: The challenges of population aging have fostered the adoption of reablement as a core pillar of older people's care in many developed economies. Aligning with wider literature on the association between "patient" engagement and outcomes, emerging evidence points to the impact user engagement may have on reablement outcomes. To date, existing research on the factors implicated in engagement with reablement is rather limited.

Objective: To identify and describe factors which impact user engagement in reablement from the perspectives of reablement staff, staff in interfacing services, service users and family members.

Sample and Methods: A total of 78 staff were recruited from five sites across England and Wales. Twelve service users and five family members were recruited from three of these sites. Data were collected via focus groups with staff and interviews with service users and families, and subject to thematic analysis.

Results: The data revealed a complex picture of factors potentially impacting user engagement, ranging from user-, family-, and staff-centered factors, the nature of the relationship between staff and users, and aspects of service organization and delivery across referral and intervention pathways. Many are amenable to intervention. As well as offering a more fine-grained understanding of factors reported by previous research, new factors impacting engagement were identified. These included staff morale, equipment provision systems, assessment and reviewing processes, and attention to social reablement needs. Aspects of the wider service context (eg, degree of integration of health and social care) played a role in determining which factors were pertinent.

Conclusion: Findings highlight the complexity of factors influencing engagement with reablement, and the need to ensure features of the wider service context (eg delivery models, referral pathways) do not work against securing and sustaining older people's engagement with reablement.

Keywords: older people, patient engagement, reablement services, intermediate care, integrated care

Introduction

Reablement is an intensive, time-limited intervention delivered in people's homes with the objective of maintaining or regaining skills and capacity to manage daily activities and maximize independence.¹ Daily visits by trained staff support regaining of skills and confidence with equipment often introduced to support this. The intention is that, over time, the frequency of visits is reduced culminating in discharge with no onward referral to long-term care. The key principles distinguishing reablement from "traditional" home care are its independence-oriented, strengths-based approach, the practice of "doing with" as opposed to "doing for", and a risk aware, as opposed to risk averse, approach.¹⁻³ Emerging in the mid-2000s, reablement represented a paradigmatic shift in the approach to the care and support of older people.^{1,3-12} The growing challenges of population ageing, and unsustainable demands on long-term care, have driven its implementation in many developed economies, though the way it has been operationalized varies.^{1,5,13-15}

In the UK, reablement is provided free of charge for up to 6 weeks. It is either delivered directly by local public sector adult social care departments (in-house service) or that department commissions the private /voluntary sector to provide a reablement service (outsourced service). Reablement teams comprise staff who carry out the home visits, staff responsible for case management, assessment and reviews, and a service manager. Some teams also include occupational therapists (OTs). Unlike some other countries, it is highly unusual for other health professionals to be represented on the team, though the reablement service may jointly work with community physiotherapy and nursing services.¹⁶ There are two referral pathways: hospital discharge or community. The latter may be a self-/family referral, or referral from primary health care or another social care service. Whilst social care departments in all localities (known as local authorities) are required to have a reablement service, there is no prescribed delivery model. As a result, different service delivery models exist; characteristics distinguishing between them include: in-house/outsourced services, presence of occupational therapy in the team, and degree of integration with health services, particularly hospital discharge teams.¹⁶

Despite the positioning of reablement as a core pillar of aging policy in many developed economies, evidence regarding its effectiveness and cost-effectiveness remains mixed or equivocal.^{17–19} To some extent, conflicting evidence can be explained by variance in the delivery model (eg duration, scope of intervention, multi-disciplinarity of staffing),^{1,16,18,20} and study design.^{21,22} Whilst there clearly needs to be further, robust evaluations of reablement, it can be argued that it is equally important to investigate what factors impact or influence reablement outcomes.²³ This is because existing research suggests that the degree to which an individual engages with reablement is a key factor impacting reablement outcomes.^{5,8,16,20,24–31} This is not surprising given the substantial body of evidence across multiple sectors (eg healthcare, education, work/management, community development) on the critical importance of user engagement with an intervention in securing intended outcomes.^{32–39}

Whilst different terminologies, conceptualizations and theories of user engagement have emerged from different disciplines and types of intervention, there is commonality across the literature in the notion that engagement is a multi-dimensional construct, comprising both an internal state and process.^{40–42} State refers to the extent to which a person is cognitively and emotionally engaged with an intervention, typically observable in behaviors and verbalizations. The notion of engagement as process refers to the fact that it is both dynamic and co-constructed between the practitioner and individual.^{40,42,43} This highlights the role of the practitioner in achieving a state of engagement and challenges previous thinking which located “the problem” entirely with the “patient”. Furthermore, there has been a growing recognition of the potential impacts of the family, service context, and cultural and societal factors on engagement.^{44–48} Reflecting this are calls for a socio-ecological approach to both how engagement is conceptualized, and the interventions required to improve engagement.^{44,49–53}

In terms of reablement, existing research suggests that a key reason for poor or slow engagement is a lack of understanding of reablement in terms of its objectives and its contrast to “traditional” homecare.^{13,16,24,54–56} The need for effective information and communication strategies has therefore been highlighted both by research and implementation guidance.^{8,22,25,27,29,30,55,57,58} However, less is understood about what those information and communication strategies need to look like.

In addition, findings from previous studies indicate that multiple other factors may be relevant. They include a number of person-centered factors, including psychological (eg self-efficacy, mood), physical (eg vitality, mobility) and cognitive (eg delirium, memory impairment) factors.^{13,16,25,59} The role of family members in securing and sustaining engagement has also been reported.^{2,4,16,30,57,60–62} Also implicated is the nature and quality of the relationship between the older person and reablement staff.^{4,7,20,25,59,61,63,64} Finally, existing work indicates that reablement staff’s understanding of, and adherence to, reablement principles, communication and motivational skills, and duration of reablement visits may impact engagement.^{8,10,13,20,21,26,30,59,64,65}

However, whilst indicating the potential range and diversity of factors which may affect an older person’s engagement with reablement, the existing evidence base remains relatively sparse,^{16,54,55} with much of it focused on the initial stages of the reablement process.^{13,29,63} Care must also be taken when interpreting research findings across countries given differences in delivery models, health and social care integration, and culture.^{1,3}

This paper reports a study seeking to identify factors relevant to older people’s engagement with UK reablement services. It was grounded in the socio-ecological perspective of engagement which acknowledges the multiple sources of

influence on intervention engagement.⁴⁴ The study comprised the first stage of the EAGER project⁶⁶ which is developing an on-line “toolkit” for reablement services which: i) supports identification of key points, actors and processes that may be affecting engagement with reablement; and ii) offers evidence-informed suggestions and materials to address identified issues.

Methods

Design

As with much applied health and social care research, a generic qualitative approach^{67,68} was used to explore the views and experiences of service users, family members, and staff working in reablement services, interfacing community and hospital services and those in strategic positions in social care departments. Focus groups with staff and individual/dyadic interviews with services users and family members were used to collect data. Fieldwork with both samples took place at the same time.

The study was approved by the University of York’s Department of Social Policy and Social Work’s Research Ethics Committee (SPSW/S/22/12). The researchers (BB, CC) are applied health and care service researchers and do not hold professional clinical qualifications.

Research Sites: Sampling and Recruitment

Research sites (that is, local authorities in England and Wales) were selected which represented different geographical and socio-demographic characteristics, reablement delivery models, and differences in the wider service context. Potential sites were identified via the team’s existing research and service improvement/development networks. Service managers and/or strategic leads in six sites were approached regarding study participation with five agreeing to take part, three in England and two in Wales, see [Table 1](#).

Study Participants: Sampling and Recruitment

Staff

We sought to represent a range of different staff groups in the study. From reablement services, this included both reablement support workers (RSWs) and staff responsible for case management, assessments and reviews and service managers. In addition, we sought to recruit staff working in services which referred to, or joint-worked with, reablement services (eg, staff from hospital discharge teams and community physiotherapy and occupational therapy services) and strategic leads in local social care departments. For the purposes of this study, staff other than RSWs are collectively referred to as “senior staff”.

A senior member of the reablement service in each site acted as “lead contact” and was responsible for overseeing identification of potential study participants, distribution of study recruitment information and making arrangements for the focus groups and interviews. A total of 78 staff were recruited, including twenty-one RSWs, fifty-five senior staff, and two participants with unreported roles. Most were female (n=70), reflecting the demographic of this workforce. A range of experience of working in/with reablement was represented, see [Table 2](#).

Users and Family Members

The research sites were also asked to support recruitment of users and family members. Two of sites did not have capacity to do this, thus users and family members were recruited from three of the five research sites. The lead contacts in each site liaised with team managers to identify 3–4 potential participants. Study eligibility criteria were: soon to be/ recently, discharged from reablement, and without significant cognitive/memory impairment. Sites were also asked to ensure hospital discharge and community referral pathways were represented. Service staff introduced the study and passed on the study information to potential participants and liaised with the research team regarding interview arrangements. A member of staff also accompanied the researcher to the interview. A total of 12 service users (Site A: n=3; Site B: n=6; Site C: n=3) and five family members (of four of the service users) were recruited. Family members included two adult children (one of which lived with the service user), two spouses (one identified themselves as the service user’s carer), and a brother. During one interview, it quickly became clear that the user could not sufficiently

Table I Overview of Research Sites

Site ID	Geographical and Socio-Demographic Features ^a		Wider Service Context		Service Characteristics				
	Geography Rural/Urban Classification	Socio-Demographic Characteristics	Type of Local Authority	Operationalized Integrated Health and Social Care System ^b	Hospital Discharge via HomeFirst Service ^c Integral or Separate to Reablement?	In-House or Outsourced Service?	Occupational Therapist(s) Core Member of Team?	Large Majority of Discharge Referrals from a Single Hospital?	Formal Joint Working Arrangements Between Reablement Service and Majority Hospital Referrer ^d
A	Urban with significant rural	Population density: <300/km ² Ethnicity: non-white <10%	Unitary authority	No	HomeFirst service integral	In-house only	Yes	No	n/a
B	Largely rural	Population Density: <200 km ² Ethnicity: non-white <10%	County council	No	HomeFirst service separate	Mainly in-house, some cases referred to agencies	Yes	No	n/a
C	Urban with major conurbation	Population density: <1500/km ² Ethnicity: non-white >20%	Metropolitan district council	No	HomeFirst service integral	In-house only	No	Yes.	Reablement service part of the multi-agency integrated discharge team
D	Mainly rural	Population density: <500 km ² Ethnicity: non-white <5%	County borough	Yes	HomeFirst service integral	In-house only	Yes	Yes	No
E	Largely rural	Population density: <50/km ² Ethnicity: non-white <5%	County council	No	HomeFirst service integral	In-house only	No	No	n/a

Notes: ^aInformation from Census 2021 and local government websites. ^bIntegrated care systems are partnerships of organizations that come together to plan and deliver joined-up health and care services.⁹⁰ ^cHomeFirst is a UK “discharge to assess” policy in which reablement potential and long-term care needs are assessed post-, rather than pre-discharge.⁹¹ ^dOnly reported where a single hospital is the source of a majority of discharge.

Table 2 Staff Participants by Site

Site ID	Staff Group	Number Recruited	Time Working for/with Reablement			
			<1 Year	1–3 Year	> 3 Year	Missing
A	Reablement support workers	4	2	2	2	4
	Senior members of reablement team	5				
	Staff from interfacing/joint-working services	-				
	Strategic leads	1				
B	Reablement support workers	3	2	2	7	-
	Senior members of reablement team	4				
	Staff from interfacing/joint-working services	4				
	Strategic leads	-				
C	Reablement support workers	4	4	6	-	6
	Senior members of reablement team	8				
	Staff from interfacing/joint-working services	-				
	Strategic leads	3				
	Unreported	1				
D	Reablement support workers	9	3	7	13	3
	Senior members of reablement team	8				
	Staff from interfacing/joint-working services	6				
	Strategic leads	2				
	Unreported	1				
E	Reablement support workers	5	2	1	3	9
	Senior members of reablement team	4				
	Staff from interfacing/joint-working services	2				
	Strategic leads	4				
Total		78	13	18	25	22

recall using the reablement service. This interview was terminated in a timely manner and excluded from data analysis. Of the 11 service users retained, the majority were women (n=7), and over 70 years old (n=10) and lived alone (n=8).

Data Collection

Data collection took place between April and August 2022. Topic guides (see [Supplementary File 1](#)) were used to ensure consistency of the topics covered with each sample. The content of the topic guides was informed by existing research and discussions with reablement staff and researchers during the initial months of the study.

We had aimed for separate focus groups for senior staff and RSWs; however, groups were typically mixed. Two focus groups were held in four sites, and three in the fifth site (to accommodate the number of staff wishing to take part). All were conducted using Microsoft Teams video-conferencing. Focus group duration was 60 (n=5) or 90 minutes (n=6), depending on staff capacity. Topics discussed included: patterns of engagement with reablement, factors impacting

engagement, experiences of addressing poor engagement (or plans/aspirations) and ideas regarding potential solutions. The depth of discussion on each of these topics varied according to the role(s) represented in each group.

Interviews with users were conducted in person ($n=9$) or by telephone ($n=2$). Where family members also took part in the study ($n=5$), a joint, in-person interview was conducted. Interviews lasted 15–60 minutes (average: 34 minutes). Topics covered included: reasons for referral to reablement service, recollections of referral process, understanding of the reablement approach, experiences of receiving the service, views on ways in which referral and delivery process could be improved. Both researchers (CC, BB) conducted data collection. With participants' permission, all focus groups and interviews were audio-recorded. Verbal consent was recorded at the start of the interview, including publication of anonymized responses.

Data Analysis

Audio-recordings were transcribed *ad verbatim*. Data analysis adopted a thematic approach, specifically the Framework method.^{69,70} One researcher (CC) led on the analysis with regular review and discussion of analytical outputs with the other researcher (BB). Key objectives of the analysis were to identify and understand: patterns of engagement, processes and factors implicated in securing and maintaining engagement with reablement, and impacts of delivery model/contextual factors and individual differences (service users and families) on these factors and processes; stage(s) in the referral and care pathways when these factors are more or less relevant; interventions to sustain or increase user engagement with reablement, including factors which may constrain or impact efforts to addressing/intervene to improve engagement.

In accordance with the Framework method, analysis began with familiarization with the data by listening to the audio recordings and reading transcripts. Alongside this, researchers created running notes of overall impressions, topics/issues, and specific thoughts about the data. Following this, two coding frameworks were developed, one for staff focus groups and one for service user/family member interviews, comprising *a priori* and emergent issues and concepts, and tested on two focus group and three interview transcripts before finalizing. [Supplementary File 2](#) presents the final coding frameworks. Transcripts were then carefully scrutinized with segments of text marked and labelled with the relevant code. Next, coded data were extracted into matrices, one for the staff data and another for the service user/family member data, created in Excel. Each column was designated to a specific code. Data from each focus group or interview were extracted into a single row. Extracted data was scrutinized and analytical notes used to describe the data and compare within and between study participant groups. Analytical notes were revised and refined in an iterative process following research team meetings to review analytical outputs. Visual displays⁷¹ were used to facilitate data analysis and present identified factors and the relationships between factors.

Results

Focus group discussions confirmed that challenges with securing engagement with reablement remain a predominant issue for reablement services. In addition, most sites described efforts to address this and reflected on the success or failure of such initiatives.

Before moving on to describe findings regarding the factors study participants believed impacted engagement, and by way of providing context for those findings, we first briefly report staff's observations on patterns of engagement from the point of entry into a reablement service. Throughout, we use *verbatim* quotes from focus groups and interviews to illustrate our commentary of the findings.

Patterns of Engagement with Reablement

Different patterns of engaging with reablement were reported by staff. However, whilst day-to-day fluctuations in mood or energy levels, or episodes of minor ill health, were described as potentially impacting user motivation and capacity to engage in reablement tasks, such impacts were transitory, and staff firmly distinguished this from issues with engagement.

... sometimes people were ... getting on really well ... [sometimes] they have a bad day, and they go back a bit ... then they go forward a bit (Site B, RSW)

Four broad patterns of engagement were identified, with Pattern C presented as more unusual.

- Pattern A: engaged from the outset and maintained to discharge.
- Pattern B: resistance to, or confusion about, reablement shifts to engagement, which is then maintained to discharge.
- Pattern C: engagement is followed by disengagement, with no subsequent re-engagement.
- Pattern D: resistance maintained until discharge.

With respect to patterns B and C, staff observed that changes in engagement could be gradual or in the form of significant step changes, or “turning points”. Some “turning points” were located in, or due to, specific stages within the intervention pathway (eg the goal-setting process). Others could occur at any moment during reablement (eg experiencing progress), or were unrelated to reablement (eg sudden onset of significant physical ill-health).

These different patterns of engagement indicate that what happens over the course of referral and intervention pathways is relevant to understanding factors which may influence engagement. As such, this offers important contextual information to understanding the main study findings on factors that affect user engagement with reablement.

Factors Impacting Engagement

The data revealed a complex picture of multiple factors potentially impacting engagement with reablement, positively or negatively, across referral and intervention pathways, see Figure 1. They included user-, family-, and staff-centered

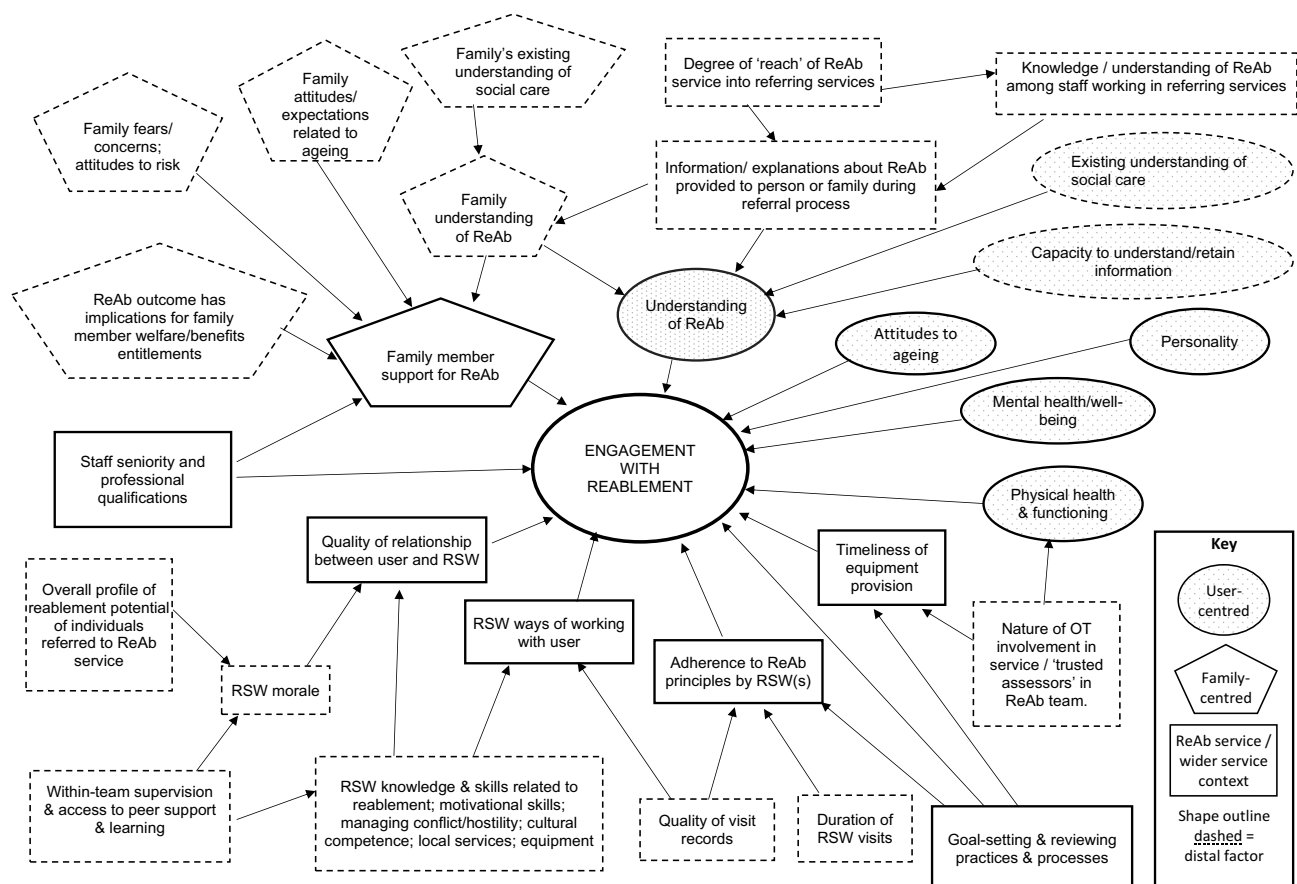


Figure 1 Conceptual map of study participants' views of factors impacting engagement.

factors, the relationship between user and reablement staff, and service organization and delivery factors. Distal, or contextual, factors influencing one or more elements directly implicated in engagement were also identified. Some factors had the potential to influence engagement at any point across referral and/or intervention pathways (eg understanding of reablement), others were located in specific stages on the intervention pathway.

The factors set out in [Figure 1](#) include both those amenable and not amenable to change or intervention by reablement (and/or interfacing) services, or strategic changes to the delivery model. In reporting our findings, we offer greater detail on factors amenable to change, thus maximizing the study's value for reablement policy and practice. There was one area where evidence was equivocal: this concerned whether the referral pathway (hospital discharge vs community) was implicated as influencing engagement with reablement. Here it was unclear whether observed differences in engagement were due to the circumstances surrounding the referral or to the quality of information provision about reablement in referring services.

User-Centered Factors

Attitudes to Aging

Apparent in staff, users' and family members' accounts was the potential influence of attitudes to aging (specifically dependency was regarded as inevitable and/or acceptable) on engagement, both at the outset and in terms of sustaining engagement when setbacks were encountered. Attitudes to aging were regarded as being influenced by societal and family attitudes, and whether or not previous experiences of adversity had been successfully overcome.

... when you're older ... all these people telling you what's good for you ... you're totally just like sat there ... and no power at all (Site C, senior staff)

Understanding of Reablement

The impacts of users' understanding of reablement on engagement was a dominant theme in the focus groups with staff. It was regarded as having the potential to influence engagement throughout the intervention period.

Staff consistently believed that the information and explanations offered during the referral period could play a critical role in determining readiness to engage or, equally, engender a resistance to reablement. Thus, poor knowledge and understanding of reablement by staff in referral pathways (eg "first point of contact staff", hospital discharge teams) – particularly the differences between reablement and "traditional" homecare – was identified as pivotal and an area where reablement services had struggled to gain improvements.

One comment we had in our last [client experience] questionnaire was quite explicit. It said, "I had no idea who was coming or what was being provided, or how it was organised or paid for" (Site E, senior staff)

In terms of those referred at hospital discharge, the lack of reablement service staff's presence in hospitals, or joint working with discharge teams, was consistently regarded as a key reason for poor understanding of reablement among new referrals. This problem was further exacerbated where hospitals were referring to reablement services in multiple local authorities, particularly where there were differences in the words used in service titles, with "reablement" sometimes not featuring at all. This made efforts to train and educate hospital staff very challenging.

Our interviews with users and family members confirmed the challenge of building an understanding of reablement. None could recall receiving any written information about the service during the referral process, despite the fact that all sites reported using information leaflets. This could be explained by the design and readability of leaflets, the relevance or meaningfulness of the information provided, and failure to offer repeatedly. Furthermore, none appeared to have had a full understanding of the reablement prior to meeting service staff.

I don't really know much about it [reablement] ... my son went to the doctor to see about getting some help ... I didn't know much about it until [senior staff] turned up (Site B, service user 03)

Other factors frequently identified by staff as having the potential to threaten a good understanding of reablement were existing beliefs about social care (including reablement and entitlements to care), and a reduced capacity to attend to,

understand or retain information due to trauma, confusion, or a fixation on “getting home”. Here both staff and users stressed the importance of repeated explanations and ongoing consistency of information provision.

... she [senior staff] told me what it was and how it worked ... she came several times, not just once ... (Site B, service user 01)

Finally, family members could play a role in supporting (or dis-abusing) understanding of reablement, though this was dependent on the information given to them and their own existing beliefs and understanding about social care.

User Personality

Finally, staff frequently referred to aspects of service user personality (eg optimistic/pessimistic, locus of control) as playing a role in user engagement with reablement, either increasing the likelihood of engagement or making it more challenging for staff to secure engagement. Staff also noted the importance of working with, or accommodating, individual differences in personality to overcome resistance or maximize engagement.

Family-Centered Factors

Family members (particularly adult children) were consistently identified as having the potential to significantly impact engagement with reablement. Overall, they were more likely to be described as a barrier or threat to engagement, as opposed to supporting engagement. Staff reported that family members sometimes directly opposed the service being involved, contacting the service to ask that they withdraw, or put pressure on users not to engage with reablement activities. Alternatively, they did not actively seek to find ways to support the reablement process. In contrast, some families were described as collaborative and supportive. This ranged from managing the logistics of micro-living (eg moving bed etc. downstairs), wanting to learn how they could support progress between visits, and offering emotional support to the user. However, sometimes the presence of family members could be overbearing and obstructed staff independently relating to and working with users.

... we have a lot more sort of breakdown [in the relationship between carer and RSW] if it's a spouse ... because they're there all the time, so they [RSWs] ... find it really hard ... to get in and support ... (Site B, RSW)

In seeking to understand family member resistance to reablement, staff noted the potential psychological impacts on family members of a referral to reablement in that it signals (perhaps for the first time) deterioration or increased vulnerability. In many instances, it occurs alongside the trauma of an acute admission. They believed this context of change and uncertainty could make families more risk averse and controlling.

... and his family were saying “Don’t do anything when the workers aren’t there”. And ... he was sort of taking that as gospel (Site A, senior staff)

Similar to users, staff identified a lack of understanding of reablement and its potential benefits as a key influence on families being unsupportive of reablement. Staff attributed this to inadequate or inaccurate explanations about reablement (particularly during referral), as well as attitudes to aging and wider understandings of social care. Further factors impacting support for reablement included concerns about their family member’s safety (eg falls), a disbelief about the user’s capacity to be reabled, and a desire to avoid (an increase in) caring responsibilities.

... you’ve got someone who’s saying that they want to go out more, they want to do this more or be more independent. Then their family might not want them to do that, because they’re worried, they’re going to fall or get injured, or sometimes have more independence (Site D, senior staff)

For some, the time-limited and tapering nature of reablement ran counter to their need for ongoing reassurance about the user’s welfare. Staff believed this latter issue was exacerbated by geographical distance. Indeed, in one site where migration of adult children from the area was very typical, the reablement service routinely used home monitoring systems to overcome this.

A lot of times it’s family who don’t live locally ... [and they say] “But I want to know someone’s going in to see my mother”. (Site C, senior staff)

Finally, and more unusually, families could be resistant to reablement where the older person's increased independence threatened welfare/carer payments received by the family.

[they] want to work with you and then the family come in and tell them not to, because they [family members] won't get that ongoing [financial] support ... if they show that they can do everything (Site B, RSW)

Staff-Centered Factors

Seniority and Professional Status

Senior staff and those with a known profession (eg OT) were consistently regarded as playing a key role in securing or regaining engagement. Whilst this was partly attributed to their skills or early involvement in a case, seniority in itself, or professional qualifications, were believed to engender acceptance of, or trust that, reablement was the correct intervention.

A lady actually told one of our girls the day before "I don't want you ladies back in the purple". And the following day we went back and there's a note in the door with the folder outside ... But then we did get the OT involved and after that, the lady was fine and it all sort of went smoothly, she was OK (Site B, RSW)

Staff Well-Being and Morale

Reablement support workers often presented paradoxical accounts of the work they did. Thus, they reported it to be a highly rewarding role, but also described their struggles to consistently practice reablement principles and provide the best quality service in the face of resource constraints, high caseloads and time pressures. The sometimes relentless nature of this experience had the potential to be demotivating and threaten their commitment to adhering to reablement principles. "Difficult" or resistant service users and families also threatened morale and well-being, particularly when caseloads did not include users who were engaged and making good progress.

The Relationship(s) Between User and Staff

Staff agreed that the quality of relationships between users and staff affected engagement. Features of the relationship regarded as particularly relevant to engagement were trust and a sense of shared endeavor. The importance of positive user-staff relationships was highlighted by the fact that all sites re-allocated staff if "mismatches" between a user and member of staff were reported.

Users and family members often described staff who had worked with them in positive terms, with kindness, respect, sensitivity, and personal warmth clearly valued. However, focus groups with staff revealed threats to them being able to develop, sustain and nurture positive relationships with users. These included impacts on morale and well-being caused by high caseloads and resultant pressures on visit duration, frustrations of working with resistant/ "hard to engage" users and families, and increased numbers of users with lower reablement potential.

Service Organization and Delivery Factors

A number of factors related to the organization and delivery of reablement, as well as staff training and support practices, were identified as relevant to engagement.

Goal-Setting Practices

Staff believed a number of different but connected aspects of goal-setting practices could impact engagement. First was the timing of goal-setting, particularly for those discharged from hospital. Attempting this immediately after discharge was regarded as sub-optimal, not allowing sufficient time for recovery from discharge and settling back home. Second was the amount of time available to explore and identify personal and meaningful goals, which was often described as limited. Alongside this, history-taking and risk assessment processes took precedence, leaving users with little energy and capacity to engage in goal-setting. All these issues were identified as increasing the likelihood for goal-setting to be staff-led and not sufficiently personalized. The absence of personalized goals was regarded as both hindering user understanding of reablement and ownership of reablement goals. It also appeared to influence the degree to which goals were

subsequently referred to or used as a motivational tool by staff. To overcome these issues, some sites had introduced a staged approach to goal-setting, with initial generic goals revisited and personalized a few days later.

Reviewing Process

Reviewing processes (eg frequency of reviews, involvement of reablement support workers, the comprehensiveness and independence of the reviewing function) varied between sites. Staff believed reviewing processes could contribute to engagement, positively or negatively, and identified a number of mechanisms by which this could happen. These included ensuring reablement support plans reflected and built on progress made, timely identification of resistance and deciding on management strategies, and identification of “mis-matches” between staff and users (or their families) and the timeliness of actions (eg updating care plan, goals and conversations with unsupportive family members) identified by the review process.

They can feel that we are not supporting them as much as we should, because we say, ‘Look, I’m afraid we can’t do that because I have to wait until your care plan has been changed.’ That’s all quite negative, isn’t it? Instead of being proactive all the time (Site E, RSW)

Equipment Provision

Staff consistently identified that the timeliness of the provision of equipment had the potential to impact levels of engagement. This was because a lack of equipment could block further progress towards reablement goals or slow the rate of progress.

Alongside OT-assessed/prescribed equipment, staff noted that introducing simple, non-prescribed equipment (eg sock/stocking aids) offered immediate positive feedback to users and helped to maintain engagement. Systems and practices which allowed such items to be very rapidly acquired by RSWs was viewed as a potential quick win for services.

...very basic, simple equipment that we’ve had put in place has enabled a lot of people (Site C, RSW)

Adherence to Reablement Principles

The degree to which reablement principles are consistently implemented by staff was identified as having the potential to affect engagement, particularly where engagement was tenuous or there was resistance. Inconsistency was identified as confusing and, for those experiencing or wishing to make progress, discouraging. Time allocated to visits (including flexibility around visit duration), the extent of resistance, and staff willingness to engage with that resistance could impact the degree to which staff adhered to reablement principles.

They [RSWs] don’t want to get into that confrontation, so you find they’ve done it for him again, and then you’ve gone back again, and then they [users] don’t really want that [reablement] support (Site C, RSW)

Social Reablement Capacity and Practices

Some staff noted a paradox in that reablement seeks to achieve greater independence for older people and yet, in doing so, can create a dependency on the companionship offered by regular visits. As a result, news of reduction in intensity of visits or plans for discharge could trigger reduced levels of engagement by the service user in order to slow progression towards goals. Staff in some sites represented noted that this was one reason why their service sought to re-connect users with existing social networks and/or support connecting in with community social activities. However, not all sites had the capacity to do this, or there was limited availability of such provision in the locality.

If someone can’t get out of their home ... they can’t access the community, and yet no one is coming in to them, why would you then want that to come to an end? (Site D, senior staff)

Quality of Visit Records

The quality of information entered into the reablement record by RSWs was also implicated in securing and maintaining engagement, particularly when multiple staff were involved. Staff believed such records have the potential to allow sharing of learning about ways of working which suited and motivated a particular user and individualized solutions to achieving a particular activity, as well as ensuring progress was acknowledged, reinforced, and consolidated. However, inconsistencies in the level and types of detail recorded, and time pressures, compromised the extent to which visit records could be used to support engagement.

Training and Staff Support Practices

A number of previous sections have described the knowledge and skills required to both manage resistance or disengagement and develop and sustain engagement. These are wide-ranging, including relationship-building, communication skills, conflict management, and knowledge of equipment and local services. Training and staff support practices varied between sites (eg duration of induction, routine opportunities for peer support and learning, systems by which less experienced staff can involve more senior staff). Staff highlighted the importance of adequate induction and training processes and ongoing supervision and peer learning opportunities for reablement support workers.

Discussion

This paper reports findings from research which sought to identify the factors which may affect engagement with reablement; a critical issue given evidence suggests that engagement impacts reablement outcomes. Multiple factors present in referral and/or intervention pathways were identified, both those directly impacting engagement and more distal factors. They included user-, family-, and staff-centered factors, the relationship between user and reablement staff, and features of service organization and delivery (see [Figure 1](#)). Our findings align with existing research as reviewed in the Introduction. Furthermore, this study adds to and develops existing evidence in three ways. First, it identified factors across the entire referral and intervention pathway. Second, by taking a socio-ecological approach⁴⁴ to understanding engagement, it intentionally investigated factors located in the service delivery model and wider service context. Third, it offered a more fine-grained understanding of already identified factors. In discussing our findings, we first consider them in the context of the wider literature of intervention engagement before focusing particularly on those findings which are novel and/or raise interesting or challenging implications for policy or practice.

In terms of contributing to the wider literature on engagement, to date, our understanding of engagement is principally informed by research on chronic condition management, rehabilitation, and mental health difficulties.^{72–74} There has been little work on social care interventions, nor which considers engagement where the intervention period is short and time-limited, as is the case with reablement. Furthermore, and again unusual in much existing work on engagement, reablement happens in people's homes as opposed to the clinic.^{5,8} The time-limited nature of reablement means services have little time to overcome resistance or retrieve disengagement, unlike many other healthcare interventions. However, the level of intensity is potentially much higher with possibly multiple visits from staff in a single day which, intuitively, would appear to support engagement. Against this is the fact that a number of staff may be working with a service user. However, despite these differences, staff described similar patterns of engagement to those reported in the wider literature.^{75,76}

An interesting feature of reablement, and again different from many healthcare interventions, is much of the work to develop and sustain engagement is carried out by staff who are not professionally qualified.^{10,77,78} In line with previous work,^{63,79} our findings repeatedly highlight the nuanced and skilled way staff work with service users and, often, family members (something we explore further below). Such findings align with calls for greater recognition of the multi-relational, complex, and skilled work carried out by non-qualified staff.⁸⁰ Our findings also reiterate the importance of equipping reablement staff with the skills and resources to secure and maintain engagement.

One of the most dominant themes across all the focus groups with staff was the role that family members can play in preventing, supporting, or undermining user engagement. Indeed, families were typically presented as a barrier to user engagement, with multiple reasons for this identified. This echoes findings from earlier UK studies.^{16,30,56} However, research in other countries (eg Scandinavia, Ireland, Canada) presents family members differently. Here the family is

typically presented as a resource for reablement staff to draw on and work with,^{27,29} or family resistance is downplayed or presented as a minor issue.^{26,78} For example, a recent Norwegian study reported that adult children encourage their parents to receive reablement services, feel responsible for service delivery, and have a strong will to initiate cooperation with services.²⁸

What is not clear is whether these apparent differences are merely an artefact of studies having different research foci, or whether there are other explanations. These could include broader differences between countries in the extent to which adult social care seeks to work in partnership with families or regards family as collaborators.^{81–84} Thus, whilst family-centered approaches are stipulated in UK national policy,⁸⁵ it has been argued that they have received insufficient attention from local authorities responsible for social care delivery.^{30,86}

Cultural and demographic factors may also be at play, eg adult child migration away from place of birth, expectations around caring. Finally, differences in the way reablement has been implemented between countries may be contributing to these apparent differences in the way families are typically regarded by reablement services. However, the identification of family as one of the most commonly reported factors impacting user engagement indicates the need to re-consider and seek to re-position the place of families in UK reablement. Sumpter (2021) makes the same argument, calling for a family-centered approach in which the potential role of families is recognized, appreciated, and supported, and their needs are incorporated into the intervention.

Numerous studies report poor understanding of reablement among service users and their families, particularly on arrival into the service.^{13,16,24,54–56} However, the factors contributing to this have remained under-explored. Our finding suggests multiple factors are at play. The key is public and health professional awareness and understanding of reablement, an issue highlighted by another UK research.³⁰ These findings point to the need to raise public understanding and awareness of reablement. There are examples of attempts to do this at a local level, eg poster/multi-media campaign in public areas of local hospitals. However, little is known about their effectiveness. For health professionals, the need for an improved understanding of social care is increasingly acknowledged⁸⁷ though it will take time for changes to be implemented and have an impact.

In line with previous work,^{30,64} we found that a reduction in visit intensity or impending discharge could threaten engagement because the user did not want to lose the companionship gained from staff visits. Staff in services where commissioning arrangements meant that social reablement could occur alongside functional reablement specifically identified the preventive role this could play in maintaining engagement. However, this was dependent on the availability of social activities in the community or befriending services, many of which were provided by the voluntary sector. In addition, partnerships with such services were often described as ad hoc. The implications of this are two-fold. First, it supports the argument that social reablement can support functional reablement outcomes. Second, it highlights the need for services to have the capacity for more formalized arrangements with community-based social activities and resources.

Previously, the problem of “patient” engagement was located in the patient. However, there is now broad consensus that the practitioner/professional has a key role to play, and that engagement is a “product” of the relationship between patient and practitioner. Less considered in existing work is what needs to be in place to support practitioners in that role, and the impact of the wider service context on the patient. More recent work is starting to describe and highlight this, arguing for an ecosystem perspective which recognizes the potential role of multiple “actors”, including institutions, organizations, and the community, in intervention engagement.^{42,44,88,89} Our findings accord with this. Service organization and delivery factors and the wider service context emerged as having the potential to significantly impact engagement, and the capacity, skills and resources staff have to secure or support engagement.

Study Limitations and Future Research

The study successfully recruited sites representing different reablement service delivery models, wider service/social care, socio-demographic and geographical contexts. In each site, multiple staff, representing different roles and duration of experience, were represented as well as staff based in interfacing health and social care services. However, our sample did not include staff in agencies commissioned by a local authority to provide reablement. Whilst there appears to be a shift away from outsourcing reablement in the UK, this is a limitation. Recruitment of service users and family members proved challenging with just three of the five sites able to recruit. Reasons for this include the lack of capacity

of staff and, we would surmise, an unfamiliarity with supporting research. Asking services themselves to recruit service users introduces a risk of bias though, overall, the sample of users represented a range of experiences. In addition, among those recruited issues with recall were encountered which resulted in one interview being terminated and data not being included in the study. Though generating rich and novel data, the study design adopted for this research was pragmatic. Going forward, taking an ethnographic approach would appear to be valuable in further understanding the complex and dynamic process of engagement with reablement.⁶⁰ Finally, findings could usefully inform an observational study of factors affecting engagement with reablement, including whether they act as mediating or moderating factors.

Conclusion

This study responded to consistent evidence that, among UK reablement services at least, securing and sustaining user engagement with reablement can be a significant challenge. Grounded in a socio-ecological conceptualization of engagement, the study was deliberately broad in its focus, seeking to identify person- (user and staff) and family-centered factors, features of service organization and delivery, and factors located in the wider “ecosystem” in which reablement services operate. Multiple factors were identified, many of which are amenable to change. The findings also signal the need for a multi-layered, multi-component approach to overcome the challenge of securing sustained improvements in user engagement with reablement. Thus, the findings carry implications not only for reablement services, but also for referring services, strategic and commissioning leads in adult social care departments and integrated care systems, as well as those able to deliver public education campaigns on social care, including reablement. In addition, findings suggest seeking collaborative partnerships with families should be a core feature of reablement practice.

Abbreviations

RSW, reablement support worker; ReAb, reablement.

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Disclosure

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