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Front-line meanings of
person-centred care: an
interpretive policy
analysis based on the
views of care
professionals

Daniel Lombard

Student number 1733692

A dissertation submitted to the University of Bristol in accordance with the requirements for award of the degree of Doctor of Philosophy, Social Policy, in Faculty of Social Sciences and Law.

Word count = 76,088

Abstract

Person-centred care has become a bedrock of policy relating to adult social services in England, synonymous with high-quality care. In recent decades the idea has gained 'unstoppable' momentum as a platform for raising standards. However, person-centred care has become mired in ambiguity. There was no agreed definition of being 'person-centred' within the care sector, hampering front line implementation.

An interpretive policy analysis explored how person-centred care was interpreted by workers and managers, and which meanings were attached to the concept within their practice. One-to-one interviews were conducted with 20 care staff by telephone and online. A rich dataset of transcripts was analysed for patterns of beliefs, values and practices. Findings were presented in a typology, which epitomised participants' interpretations of the concept within three distinct approaches to person-centred practice. These were Nurturing Mental Health; Nurturing Agency; and Nurturing Intimacy.

Within Nurturing Mental Health, professionals applied psychological assessments and creative use of activities to stimulate happiness and reduced anxiety within clients. Practitioners adopting a Nurturing Agency perspective assessed clients' mental and physical capacity and encouraged decision-making and independence. Practices for Nurturing Intimacy involved seeking consent from clients to provide close personal care, and developing meaningful relationships and friendships with them.

This thesis could raise cognisance of front-line care staff's situated knowledge and experiences, which are frequently overlooked in policy debates. Its model offers a new dimension of understanding how person-centred care is understood through distinctive sets of beliefs, values and practices. It offers not only a critique of current policy definitions of the concept, but a path towards rethinking front line interpretation of person-centred care. The typology of meanings could inform a future framework for values-based training and self-reflection as part of a person-centred approach.

Author's declaration

I declare that the work in this dissertation was carried out in accordance with the requirements of the University's *Regulations and Code of Practice for Research Degree Programmes* and that it has not been submitted for any other academic award. Except where indicated by specific reference in the text, the work is the candidate's own work. Work done in collaboration with, or with the assistance of, others, is indicated as such. Any views expressed in the dissertation are those of the author.

SIGNED: DATE:.....

Statement on impact of COVID-19 on research project

Prior to the pandemic I had been planning a project about how person-centred principles were enacted in care planning meetings in residential homes. This would have involved visiting care homes in person and video-recording meetings between care workers and clients. The recordings of the client-worker interactions were to be transcribed in detail and subjected to conversation analysis. I spent several months learning about conversation analysis techniques through individual study, seminars, workshops, and conferences in the UK and overseas. The bulk of my research support grant was spent on these activities.

I submitted a detailed research proposal for this project in Summer 2019 to my University department, for the purpose of the School for Policy Studies progress review. I passed this review and applied for ethical approval from the Health Research Authority, via a research ethics committee in Wales. Following feedback from the committee, I sent a revised application and received a favourable opinion on 5 February 2020. In the meantime I had been developing contacts with people in the care sector in South West England, with a view to recruiting partners for the research.

I attended meetings with care home managers in February 2020 to explain the project and ask for their support, gaining agreement from five care providers. I was about to begin collecting data when the COVID-19 outbreak occurred in the UK. The University suspended ethical approval for all face-to-face fieldwork in March 2020, so I cancelled all planned meetings with care homes. I was unable to carry out any planned fieldwork activities, and the subsequent closure of campus meant all further studying was conducted on my personal computer at home. The University library closed for several months, meaning I could not borrow print copies of books.

After lengthy discussions with supervisors it was decided the original proposal was no longer feasible. I considered alternative angles for research on person-centred care in the long-term care sector, such as regulation, training and practice. Some colleagues suggested secondary analysis of existing interview transcripts. I reviewed training materials, policy texts, and inspection reports, but these were ruled out as possible datasets due to concerns over a lack of depth and quality and the terms of prior ethics approvals which did not allow for secondary analysis.

While retaining an overall focus on the delivery of person-centred care with older people, I settled on an alternative design. The revised project was an interpretive policy analytical study, exploring interpretations of person-centred care from the perspectives of care workers and managers. Data came from interviews with these actors; given restrictions on fieldwork caused by COVID-19, interviews were conducted remotely by videoconferencing software on computer and by telephone. Interpretations of person-centred care therefore became the revised focus of the thesis, which is submitted here.

Acknowledgements

Thanks to all care workers and managers who generously participated in the research, and employer organisations for accommodating my requests.

Thanks to supervisors, Jon Symonds and Karen West, and erstwhile supervisors Liz Lloyd and Val Williams, for sage advice and enduring support, and to Ailsa Cameron for offering useful feedback at a pivotal stage.

An intellectual debt is owed to the grit, determination and wisdom of Jenny Morris, Simon Brisenden, Mike Oliver, John Evans, et al. The disability activists who lit a bonfire under outrageous injustice, which continues to burn to this day - if I have seen further in this research, it is by standing on their shoulders.

The Economic and Social Research Council provided funding for my PhD studentship.

沢山の思い出を共有した（我が）妻茅乃に捧ぐ

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Preface

My interest in the quality of adult care services began several years prior to getting into the world of PhD studentships and academia. As a twenty-something university graduate in Cardiff, UK, I sought to carve out a career in *something*. In the absence of a clear plan of action I endured a couple of years' half-hearted temping in offices before answering an advert for an employment agency in the care and support sector. My first assignment was a housing shelter with emergency floor space for adults in crisis. As I crossed the threshold of the dimly lit foyer to clock on for my first shift, a lightbulb moment occurred: the opportunity to help people in need of support was the perfect fit for me. In a fascinating year spent in different projects around the city, I learned more about society than ever before. I was grateful for the opportunity to work with children in the care system, people with mental health problems, and adults struggling with addictions, and learned something from each person I supported. The task of building relationships with clients and helping to navigate a complex, under-resourced system, while making sense of opaque guidelines such as promoting independence, presented a unique test of my skills and knowledge. My career path later switched towards writing and research. However, the intellectual problem sparked when I first clocked into the housing project all those years ago continued to flicker in my mind. The PhD research project would allow for exploration of the same questions revolving around quality, sense-making, and interpersonal connections. This thesis is the culmination of my professional and intellectual interests built over several years and career changes. It presents an opportunity to study the thought processes and on-the-spot reasoning of care and support workers attempting to do their best for each client walking through the door of their service.

Structure of thesis

This thesis is divided into three major parts: introductory chapters, findings, and conclusion. The first part introduces the phenomenon in question and explains key components of the study's research design. Chapters 1 and 2 set the topic of person-centred care into context, discussing ways it has been examined, promoted, criticised, and discussed, in the UK and beyond. The first chapter focuses on policy, with information about the care workforce; the second examines theory. The next two chapters, 3 and 4, discuss the methodology behind my research project, in terms of the rationale underpinning the design, and the methods used.

The second part presents the research findings. It opens with Chapter 5, an overview of participants alongside initial discussion of interpretations of person-centred care from data analysis. Chapters 6-8 present substantive findings via a three-part typology of beliefs, values and practices, based on the findings of framework analysis.

The third part, Chapter, 9, concludes the thesis with discussion of key findings and recommendations for policy and research.

Chapter 1: **Person-centred care policy and the adult services workforce**

1.1 An influential, ambiguous concept permeating England's care sector

High standards of care for sick, older and disabled people are a mark of decency in any society (Kittay, 2019, p33). The quality of social care in England has risen up the political agenda in recent years. In policy debates, the idea of quality has become synonymous with the centring of services around the recipient or person receiving services (Edvardsson et al., 2010; Manthorpe & Samsi, 2016; Wilberforce et al., 2017). Persons and personhood are themselves worth exploring: the idea of a 'person' refers to the uniqueness of each human being, according to the poet, W.H. Auden (cited in van Manen, 1990). According to Jameton's seminal text on the ethics of nursing (1984), personhood is central to an ethical caring philosophy, which assumes each person is worthy of respect, their autonomous choices worthy of recognition. Within policy debates, beliefs about the value of personhood became linked to equality campaigns on behalf of adults with disabilities, typically of working age. From the 1970s onwards, activists demanded independent living for all in the UK, believing adults with disabilities were individual persons with the same rights to freedom and choices as other citizens (Elder-Woodward, 2013). Policy-makers appeared to recognise arguments in favour of individuality under the umbrella of person-centred support, which purported to shift the balance of decision-making power away from institutions and professionals and towards adults receiving care and support (Lymbery, 2012). The agenda stemmed from the assumption that the individual was best-placed to judge their own well-being (Department of Health and Social Care, 2020 - see Section 1.3 below). Consensus on the meaning of person-centred care had not been reached (Edvardsson et al., 2010), but it did not halt momentum of these powerful social

movements. They culminated in the interpolation of long-term support for adults into policies known as 'person-centred care'. The promotion of individualism became a bedrock of long-term care policy in England from the 1990s onwards.

One of the strongest mechanisms available to policy-makers to enact ideas and deliver goals is legislation (Blakemore & Warwick-Booth, 2013). The UK government steered the adult care system towards an individualist direction with two key pieces of legislation in the 1990s (National Health and Community Care Act, 1990; Community Care (Direct Payments) Act, 1996). The 1990 Act led to a restructuring of care delivery, positioning independent providers as integral to the stimulation of choice and availability of individualised services (Filinson, 1998). The 1996 Act enabled councils to offer direct payments to adults (Pearson, 2000). Together, these laws paved the way for a proliferation of practice models, regulations, and frameworks aimed at promoting people's autonomy through 'personalised' or 'person-centred care'. Policy-makers behind these schemes cited evidence linking positive outcomes for older and disabled adults being able to choose and sometimes design their own care services (Brooker, 2007; Chenoweth et al., 2009; Fossey et al., 2014; Glendinning et al., 2008; Moran et al., 2013; Wilberforce et al., 2011). In the past three decades, the idea has gained 'unstoppable' momentum (Beresford, 2008, p8) as a political slogan and platform for raising standards. A drive towards greater equality for adults of working age was so strong that adults of all ages, including older people, became subsumed within reforms to the care and support system. And policy-makers did not stop there. Attempts to build services around individual need were applied not only to social care but across England's welfare state, in education, employment services, housing, criminal justice and healthcare (Needham, 2011b).

Decision-making power may have shifted towards the individual person receiving services, but the roles of care professionals still mattered. Reforms required workers and managers to translate abstract concepts, such as the promotion of choice and independence, into everyday practice with clients.

Such sense-making responsibilities are aligned to a theory of interpretive policy analysis, which has informed the methodology behind this thesis. Under this theory, interpretation of policy by individual professionals is key to the quality of public services. In these policy implementation situations, front-line workers and managers exercise discretion and judgement, developing routines of practice through actions and reasoning (Lipsky, 2010). These practices unfold on the front line of services or 'street level', at a distance from the centre of governance where authority presumably resides (ibid). These judgements are especially important where objectives are vague and abstract: this was certainly the case here, as there was no agreed definition of being 'person-centred' within the care sector (Symonds et al., 2019). Literature has suggested ideas related to person-centred care were not easy for professionals to understand (Brooker & Latham, 2015). Some staff may have been able to extrapolate practice from values-based policies quite easily, but many others would need practical implications spelled out in concrete terms (Brooker, 2004).

Authors have attempted to construct practice frameworks to enable care providers and professionals to break down the complexities of person-centred care into achievable steps (Brooker & Latham, 2015). One such scholar was McCormack. He conducted empirical research regarding the meaning of autonomy for older people (McCormack, 2001). The author built on the findings of that study to map the core elements of person-centred care to help nurses understand and translate theory into practice (McCormack & McCance, 2006). McCormack's conceptualisation suggested the process was complex, demanding high levels of interpersonal skills and self-reflection among nurses (ibid). Not only should professionals have committed to continuous learning, they also needed to develop interpretations of personhood with clients, and be supported by an appropriate working environment (ibid). Strong, therapeutic relationships between professionals and clients were at the heart of this style of practice (McCormack, 2003). Similar attempts to aid implementation in social care were offered by Brooker. Brooker developed a framework containing 25 quality indicators to allow service providers to nurture and develop person-

centred practice, the indicators spanning broad areas of management, training, relationships, and individual practice (Brooker & Latham, 2015). Both authors, McCormack and Brooker, framed person-centred care as a complex professional concept, demanding multiple prerequisites to enable interpretation of principles into practice. The role implied staff should be equipped by advanced skills and commitment to their craft while being supported by employers. Management styles needed to be inclusive, with services backed by sufficient resources and appropriate funding (Dowling et al., 2006). Overall, a strong, overarching infrastructure was required to facilitate person-centred approaches.

Yet this necessary infrastructure in the sector in England was compromised by contextual weaknesses. In some care settings, high workloads meant some staff were unable to spend time getting to know clients, and interactions were often brief and cursory (Pillemer et al., 2003; Watson, 2015). Care workers lacked the professional status of nurses (Kingsmill, 2014) and felt undervalued in society (Care Quality Commission, 2019; Cooper et al., 2013; Hayes, 2017; Hollinrake, 2020; Kadri et al., 2018). The workforce was characterised by endemic low pay (Institute for Public Policy Research, 2018). In working environments where staff felt disrespected, it would be difficult to create an overall culture of respect necessary for the effective delivery of person-centred care (Brooker & Latham, 2015). These entrenched problems undermined opportunities for professional development, seen as crucial for effective, person-centred care. At the time of writing there was no registration system for care workers in England, therefore, no legal requirement to undertake minimum training before entering the workforce (Hayes et al., 2019). This lack of regulation limited the development of a well-trained and professionalised workforce (House of Commons Committee of Public Accounts, 2018), and standards of learning and supervision were patchy across the sector (All-Party Parliamentary Group on Social Care, 2019). These issues were problematic for the delivery of person-centred care, given the stress placed on learning and reflection in the practice models outlined above (Brooker & Latham, 2015;

McCormack & McCance, 2006). An older people's charity expressed bewilderment at the government pushing through person-centred reforms aimed at raising standards in adult care, while public spending within the sector in England was falling (Age UK, 2019). In addition, there were concerns over the suitability of individualised practice models for certain client groups – notably, older people. Commentators warned that positive outcomes in well-being for older people, attributed to person-centred care, were less pronounced compared to other client groups (Moran et al., 2013; Netten et al., 2012a; Woolham et al., 2017). Yet the embracing of the strategy within policy and legislation in England continued. As this chapter will articulate, the public legitimacy of person-centred care became so robust and the apparent inadequacy of alternative models so irrefutable, an orthodoxy of person-centredness now permeated the entire care sector (Needham, 2011b, p2).

With person-centred care cemented as a policy concept, there were numerous implications for professionals. Care workers and managers were required to develop detailed practice knowledge to help implement person-centredness on an individual level (McCormack & McCance, 2006). These interpretive faculties were crucial to their attempts to make sense of personhood, which required not only understanding values of the people they were supporting, but also their own values (ibid). Prioritising autonomy and self-determination among clients implied a greater emphasis on listening and undertaking different tasks rather than routine, pre-determined care (Hayes et al., 2019). Contradictions of the governance landscape, potentially complicating the task of implementation, were well-known. Evidence of the reasoning of front-line professionals as they attempted to make sense of person-centred policies was less established. This thesis explores front-line meanings of person-centred care among staff from an interpretive policy analytical perspective, examining the nous and logic employed in professional practice to aid an overall understanding of the concept. The introductory chapter discusses the policy context surrounding person-centred care: the influence of independent living campaigns and global strategies on individualism, definitions of the concept in guidance and

legislation, and policy development on both local and national levels. It describes two key parties: the workforce, and older people receiving care. The chapter includes commentary offering a critique of policy, drawing on arguments from selected academic works.

1.2 High-profile campaigns for independent living preceding global strategies

As introduced in the previous section, care policy reforms in England from the 1990s onwards were preceded by long-running social justice campaigns for inclusivity. The emphasis on individualist attitudes within policy and practice has been attributed to advancement of the independent living movement. Disability activists such as Ed Roberts made headlines in the United States in the 1960s (Washington Post, 2020). Spurred on by this raising of awareness, counterparts in the UK in the 1970s and 1980s campaigned for an end to people being discriminated against on the grounds of disability, advocating for a more egalitarian social world. One of the tenets of independent living was that disability was not related to impairment, but instead bound up in socially constructed barriers of prejudice, discrimination, and exclusion (Morris, 2001). By the same token, an inclusive society meant everyone had the right to make decisions for themselves.

If we are to be treated as individuals who are due the same respect as other people, then we must be allowed to choose a way of living that confronts all the options and risks throughout life that are inherent to living in, rather than outside, society. We believe fundamentally that all individuals have the right to live independently in the community regardless of their disability.

Brisenden (1986, p178)

Brisenden, Morris and other advocates of independent living were interested in breaking down discriminatory barriers faced by adults with disabilities. They took issue with medicalised models of care focusing on impairment through books and articles laced with withering criticism of the arrogance of the ruling classes and autobiographical experiences. Authors accused society of ignoring disabled people (Brisenden, 1989); they suggested able-bodied people had a vested interest to shun disabled people and view them as objects of pity (Davis, 1987). The segregation of people with disabilities into long-stay hospitals was driven by society's need to control 'disruptive elements in its population' (Oliver, 1986, p14). Activists also took part in numerous protests to make their point. In the picture below, people with disabilities blocked an entrance to a car park outside the Houses of Parliament in London in 1983 in support of an anti-discrimination bill.

Image 1.1: Disability activists protest outside the Houses of Parliament in 1983.



Source: Disabled People's Archive, Greater Manchester Coalition of Disabled People.

Some scholars have attributed the spread of person-centred policies to the combined force of these campaigns for empowerment among people with disabilities, spread over several decades (Needham, 2011b). Arguments in favour of independent living reflected pro-human rights movements around the world, backed by powerful third-sector and global organisations. Influential bodies such as the United Nations have attempted to shape policy regarding social problems affecting countries at a global level (Deacon, 2005). For example, the Human Rights Act (1998), passed in accordance with the European Convention on Human Rights, protected people's freedom of expression. Similarly, the United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2006) called on governments to respect people's independence, autonomy, freedom to make choices, and the right to

'non-discrimination'. Meanwhile the World Health Organization (2002) endorsed policies of person-centred, long-term care. The body's global strategy on ageing and health included the 'quality of person-centred and integrated long-term care' as a core objective (World Health Organization, 2017, p19-20). This was because older people had highlighted autonomy as crucial to well-being; as a result, the organisation believed care providers should respect people's rights to make choices about their own care and support (ibid, p11). In a similar vein, there were calls for greater application of person-centred approaches for older people using care and support by an international human rights body, the Council of Europe (2017).

Principles underpinning these influential treaties and campaigns became embedded in European social policy, as states attempted to raise standards in long-term care through the promotion of person-centred models (Spasova et al., 2018). The UK government ratified the United Nations Convention on the Rights of Persons with Disabilities in 2009 and developed multi-layered systems of governance to support person-centred practice across England. These policy reforms are discussed in the next section.

1.3 Embedding person-centred care as a principle of adult care policy in England

Having considered the foundational arguments for individualised services, this section describes some of the key milestones in legislation and regulatory policy in which principles of autonomy and individualism became manifested. It begins with the introduction of a key mechanism, devised in the 1990s, for organising care around the views of individuals - direct payments. It goes on to describe policy developments leading up to the 'fundamental standards' of health and social care, which consolidated person-centredness as a cornerstone of policy in the 2010s.

As mentioned in Section 1.1, the Community Care (Direct Payments) Act (1996) paved the way for reforms to the care system, apparently centred around individual client need and decision-making. In a symbolic shift away from the old-fashioned 'welfare state', it overturned a prohibition on local authorities on giving cash payments to disabled people imposed by the National Assistance Act (1948), according to Scourfield (2005). The law gave adults of working age the right to claim direct payments from local authority social services, and a subsequent change to the law (Community Care (Direct Payments) Amendment Regulations, 2000) extended the scheme to include adults aged 65 and over. Direct payments, along with the linked initiative of personal budgets, were central to attempts to make care more flexible and responsive (Powell, 2012). A personal budget is a sum of money allocated by local authority social services to meet eligible needs (National Audit Office 2014). It can be either managed by a local authority or third party on a person's behalf, or given to the person as a direct payment, allowing the person to pay for their own care services and choose how the budget is spent (Department of Health and Social Care, 2020, paragraph 11.3). A direct payment is a cash payment made to individuals by state-funded services for some or all of their eligible care and support needs (Department of Health and Social Care (2020, paragraph 12.1). The introduction of direct payments was warmly welcomed by the disability community, who had argued for social policy tools reflecting their status as autonomous individuals for many years (Hayes, 2017, p165). Direct payments reflected a central principle of the independent living movement, that people with disabilities should have the same opportunity to make decisions about their lives as people without (Duffy et al., 2010, p495). These 'cash-for-care' schemes were designed to increase independence and decision-making among older and disabled people (Moran et al., 2013). The upshot was a realignment of power dynamics in client-professional relationships, allowing individuals to commission and arrange care specific to their needs. Instead of an institutionalised approach in which decisions were made on the client's behalf, the role of professionals was to have a more sympathetic presence. Professionals needed to acknowledge the values and beliefs of clients and share decision-making and

power in a more collaborative, holistic approach to caring (McCormack et al., 2015).

Successive governments of different political colours in the UK claimed to be champions of person-centred care. The Community Care (Direct Payments) Act (1996) was passed when Conservatives were in office. In the 2000s, Labour signalled its own commitment towards personalised support in a national quality standard for older people, aimed at health and care providers and local government commissioning officials. This was known as the National Service Framework for Older People (Department of Health, 2001). One of the core standards of the framework was person-centred care, requiring services to respect people as individuals and arrange care around their needs (ibid). The Labour government widened this agenda with a national roll-out of personal budgets, outlined in its Putting People First agreement between national and local government (Department of Health, 2007). One of the politicians at the forefront of reforms was care services minister Ivan Lewis. In reference to Putting People First, Lewis wanted to encourage the majority of adults in the care system to start receiving personal budgets over the next three years (Lewis, 2008). The minister made a speech to Parliament explaining the government's thinking, with a caveat that the policy may not be welcomed by all clients with the same enthusiasm.

Some people will be able to exercise that control and choice over the use of personal budgets with little additional support. Other individuals will need a high level of support in order to make those choices and exercise that control. However, we should not hesitate to sign up to the notion that, as a starting point, everybody is entitled to self-determination and maximum control and choice.

Lewis (2007)

The policy rationale was that adults receiving state-funded care services from local authorities should be in control of how their care budget was spent. This

commitment was contained in a care and support white paper by a Labour-controlled government in 2010.

Rather than being told what services they will receive, people will be offered a personal budget, if they want one, giving them much more choice about how their care and support entitlement is spent... This reflects the direction set for the NHS to give people greater control over their own health and care.

HM Government (2010, p71)

A commitment by government to recognise and respect people's right to make their own decisions was signalled by the phrase, 'giving them much more choice', in the passage above. This individualist attitude appeared to represent a rejection of an institutionalised mindset in which professionals would tell people what services they would receive. The proposals were welcomed by some social policy authors, who became enthusiastic advocates for the life-changing possibilities of personalised care. For example, Duffy (2011, p10) quoted a speech by a politician referencing a story from a constituent, regarding a man with disabilities who was empowered through person-centred support to transform his life 'in a way he and his mother never thought possible'.

Around this time the political landscape changed again. A new coalition government led by Conservatives and Liberal Democrats launched another care and support white paper (HM Government, 2012), which claimed to make person-centred strategies a priority. In the foreword, ministers said:

We will transform people's experience of care and support, with high quality services that respond to what people want. This means that people will have control over their own budget and their own care and support plan. They will be empowered to choose the care and support that best enables them to meet their goals and aspirations.

(Ibid, p9)

When it came to enacting these policy ideas, discourse around goals and aspirations, control and empowerment, became part of the lexicon of the Care Act (2014). This law was described by government as the ‘most radical reform of the social care system in 64 years’ (Department of Health, 2012a). It strengthened the rights of people receiving state-funded care and informal carers to receive needs assessments and direct payments, created a new legal entitlement to a personal budget, and required local authorities to promote well-being among individuals (Department of Health and Social Care, 2016). There was a new duty on councils to oversee their local care market and stimulate a wide variety of high-quality services (ibid). The law set out to create a person-centred system of care, built around the ‘individual’s views, wishes, feelings and beliefs’ (Department of Health and Social Care, 2020, paragraph 1.14). As stated in Section 1.1, this policy was based on the individualist assumption that people themselves were best placed to judge their own well-being (ibid). By the same token, local authorities were considered best placed to find ways of encouraging independence among their local adult population, and were expected to engage with care providers in the area and other parties in the development of local strategies (ibid, paragraph 4.54). These expectations hinted at a broader political movement in which commissioning and policy-making powers were shifted away from central government and towards town halls and local communities. This principle of making services more decentralised was a crucial part of the Localism Act (2011), which assumed power would be exercised at the lowest practical level (Department for Communities and Local Government, 2011).

Meanwhile the UK government faced public criticism on several fronts for its oversight of care services and regulation in England. A series of failings led to premature deaths of patients at Mid-Staffordshire NHS Foundation Trust (Francis, 2013). Around the same period, incidents of bullying and assaults of disabled residents at Winterbourne View Hospital in South Gloucestershire were exposed by a BBC Panorama television documentary (British Broadcasting Corporation, 2011). The crises prompted the government to order

a public inquiry into issues highlighted by the Mid-Staffordshire case (Francis, 2013) while a separate investigation of Winterbourne View uncovered systemic weaknesses in regulation (South Gloucestershire Safeguarding Adults Board, 2012). In a separate piece of work, the Law Commission examined the content of statutory guidance on care and support in its review of regulation relating to adult social care in England (Law Commission, 2011). It found there was a 'confusing and often incoherent patchwork of legislation' which made application of regulations 'complex and time consuming' (ibid, p9). The report highlighted a 'range of disparate and unconnected pieces of statutory and practice guidance' (ibid, p13), and described the legal framework for care assessments as 'overlapping, complex and confusing and in urgent need of reform' (ibid, p31). In response to these criticisms, the Department of Health announced a package of reforms aimed at increasing safety, quality, and accountability of health and care (Department of Health, 2012c, 2014a). The UK government accepted the Law Commission's finding, that care and support law was opaque and complex, recognising there was a 'plethora of documents, whose status can be unclear, and which can cause confusion on the ground' (Department of Health, 2012b, p6). Care regulation was subsequently tightened and simplified along individualist lines, with a revised inspection framework underpinned by 'inviolable principles of safe, effective and compassionate care' (Department of Health, 2014a, p10).

The Conservative/Liberal Democrat white paper (HM Government, 2012) promised to empower people to take control of their own care, with the unspoken implication that the care workforce would be required to implement these goals. The sector awaited revisions to existing workforce regulations, which are discussed below.

1.4 Regulations and professional guidance featuring person-centred care

A new regulatory system came into effect for care providers in England in 2015 (Care Quality Commission, 2015c), making person-centred care a priority across the sector. In the same year, 2015, the government launched a training initiative, the Care Certificate, which aimed to bring a consistent approach to staff development and induction, (Argyle et al., 2020). These twin schemes interpreted quality of care in terms of safety and choices of the person receiving services, with numerous implications for the duties and responsibilities of care professionals and employers. The developments are described below.

Reforms to health and care regulation in England were designed to restore public confidence and accountability in the National Health Service in the wake of the Mid-Staffordshire scandal (Department of Health, 2014a). A set of revised guidelines for health and care providers, the 13 'fundamental standards' for health and social care in England, were introduced in 2015 (Care Quality Commission, 2015c). Ministers said the new guidance formed the non-negotiable benchmarks people had a right to expect when using services across the health and care system, and was written in language designed to be easily understandable by the public and professionals (Department of Health, 2014a). Each of the standards was reinforced by a statutory instrument (Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014), which formed a legally binding commitment for all registered providers and managers in health and social care. Regulation 9, 'person-centred care', was defined as follows.

The care and treatment of service users must:

- (a) be appropriate,
- (b) meet their needs, and
- (c) reflect their preferences.

Health and Social Care Act 2008 (Regulated Activities) Regulations (2014)

Regulation 9 added people should be supported to make decisions relating to their care and treatment, after being given sufficient information about relevant

choices available (ibid). These regulations had implications for both public expectations of care experiences, and professionals, as the regulations should inform the practice of workers and managers across the sector. However, care work was not a regulated profession, so there was no national system of governance for overseeing care workers' conduct. Instead, senior managers and providers, who were registered with the Care Quality Commission (CQC), were held accountable. As the regulator for all health and care services in England, the CQC regularly inspects some 14,800 registered providers across 25,800 locations in adult care (National Audit Office, 2021). It has the power to enter premises, issue warning notices, close failing providers, and prosecute registered individuals, with the option of issuing unlimited fines in the event of serious breaches of standards (Care Quality Commission, 2015a). Official guidance stated breaches of Regulation 9 would not constitute a prosecutable offence, but the regulator could take enforcement action against breaches of this regulation or any of its component parts (ibid). Registered managers of all care providers in England were therefore legally required to comply with the standard and deliver person-centred care.

Under its revised remit, the CQC embraced person-centredness, lauding it as the epitome of high-quality care. A report outlined the regulator's position.

[P]ersonalisation is critical so that people can identify their individual needs; be empowered to take control; and make informed choices about the way they live their lives. Good services recognise this by delivering truly person-centred care.

Care Quality Commission (2018, p4)

A clear suggestion of a relationship between quality and person-centredness was implied in the final sentence of this passage, and the proximity of the phrase 'good services' with 'truly person-centred care' (ibid). While the overall policy emphasis on person-centred care may have been obvious, methods of implementation were not specified. In one document on its website, written from the perspective of people receiving care, the regulator said professionals would

be expected to learn about the 'background, likes, hopes and needs' of clients, with written care plans containing 'information about the whole of your life, including your goals, your abilities and how you want to manage your health' (Care Quality Commission, 2017). The CQC published advice for providers and managers, which aimed to put the statutory regulations into a more practical context. This document included the following definition for Regulation 9, 'person-centred care'.

Providers must do everything reasonably practicable to make sure that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be.

Care Quality Commission (2015b, p28)

The guidance added that care assessments should cover people's needs in terms of health, personal care, and emotional, social, cultural, religious and spiritual issues (ibid, p29). This material was complemented by guidance aimed at professionals published by the sector skills council, Skills for Care. The Care Certificate, an induction programme, was aimed at newly recruited care workers and healthcare assistants (Skills for Care, 2015). It encouraged staff to develop 15 fundamental skills, knowledge and behaviours required to provide safe, effective and compassionate care (Argyle et al., 2020). The certificate was not a qualification but rather guided people's induction into the sector (ibid). The UK government explained the Care Certificate was part of its effort towards ensuring the CQC's fundamental standards, which included person-centred care as a core principle, were applied consistently throughout health and social care (Department of Health, 2014a, p109). The Care Certificate was intended to provide an overview of the fundamental skills of adult care, covering topics such as 'equality and diversity', 'privacy and dignity', 'communication', 'health and safety', 'safeguarding adults', and 'work in a person-centred way' (ibid, p2). The description of person-centred approaches in the Care Certificate echoed the wording of Regulation 9 (Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014). The Care Certificate required the learner to:

- *Describe the importance of finding out the history, preferences, wishes and needs of the individual;*
- *Explain why the changing needs of an individual must be reflected in their care and/or support plan.*

Skills for Care (2015)

According to the guidance, workers should be able to demonstrate their actions promoted person-centred values. These core principles were described as including:

- *Individuality*
 - *Independence*
 - *Privacy*
 - *Partnership*
 - *Choice*
 - *Dignity*
 - *Respect*
 - *Rights*
- (ibid, p9)*

There was no further explanation of these eight core principles within the guidelines.

The Care Certificate was complemented by an existing framework of national diploma qualifications, also overseen by Skills for Care. These training programmes were designed for staff at all levels of seniority, with the entry-level certificate, level 2 Diploma in Care, aimed at workers who had recently completed the Care Certificate. After the level 2 Diploma, experienced staff could progress to more advanced qualifications at levels 3 and 4, with level 5 aimed at management-level positions. Criteria for completing level 2 included a section titled 'Implement person centred approaches in care settings', with a

series of related skills and qualities including understanding the preferences, wishes and needs of individual clients, establishing consent, supporting the client's right to make choices and supporting individual well-being (Skills for Care, 2016a, p11-12). The supporting material reiterated the definition of person-centred values within the Care Certificate, and added several new ones.

Person centred values include:

- *Individuality*
- *Rights*
- *Choice*
- *Privacy*
- *Independence*
- *Dignity*
- *Respect*
- *Care*
- *Compassion*
- *Courage*
- *Communication*
- *Competence*
- *Partnership*

(Ibid, p13)

Five additional values appeared in the level 2 Diploma list, which were absent from the Care Certificate definition. These were care, compassion, courage, communication, and competence, bringing the total to 13 principles within this 'official' description of person-centred care. The Diploma guidance resembled the advice included in the Care Certificate, explaining that working in a person-centred way included the ability to:

Find out the history, preferences, wishes and needs of the individual;

Apply person centred values in day to day work taking into account the history, preferences, wishes and needs of the individual

| (Ibid, p12)

All subsequent levels of qualification in the Diploma framework included prominent sections on person-centred practice (Skills for Care, 2016b, 2021b, 2021c). The National Institute for Health and Care Excellence (2015) followed suit with guidelines for home care managers and workers. In a section titled 'Ensuring care is person-centred', the document said services should ensure support focused on what people can or would like to do to maintain their independence, not only on what they cannot do (ibid, paragraph 1.1.2). The same organisation published a quality standard on the mental well-being of older people in residential care (National Institute for Health and Care Excellence, 2013). This standard suggested:

| Older people should be involved in decision-making and supported and enabled to express who they are as an individual and what they want.

| (Ibid, p13)

The wording of this guidance, with its emphasis on decision-making and freedom of expression, appeared to reflect some of the principles of autonomous decision-making of international conventions for people with disabilities, highlighted in Section 1.2. Overall, these messages, endorsed by legislation and at the highest levels of government, were disseminated at a national level to the workforce in every setting and level of seniority: community care and residential care, from new recruits to senior managers. This group of actors is described below.

1.5 Introducing the care workforce

Expectations among care staff to adapt to person-centred ways of working were now embedded within policy guidance for employers and workers.

Requirements for this style of care featured prominently in training and induction

programmes for staff, approved by national bodies. This section will put the issue of person-centred care into context by describing the workforce and care settings in which it is typically enacted.

Care workers were an increasingly important group in the welfare state, frequently operating as the first point of contact with the care sector for many clients and family members. A government-funded review of the care workforce in England singled out the vital role played by workers in delivering compassionate care (Health Education England, 2015, p4). In addition, care professionals were integral to the delivery of person-centred care. This was because workers adopting this style of care could have a direct bearing on the well-being of people being supported (Stein-Parbury et al., 2012). Staff generally operated in two main settings: community care (sometimes referred to as 'domiciliary care'), in which staff provided support during timed visits to people in their own homes, and residential care, which offered round-the-clock care, board, and accommodation for adults with more advanced needs. The care workforce in England was one of the biggest in the whole economy. According to the latest workforce report by Skills for Care, as of 2020/21 there were around 1.54 million people working in adult care jobs, amounting to more than the National Health Service, which employed 1.3 million people (Skills for Care, 2021d). There were an estimated 1.28 million direct care roles, making up 76% of the total, and 110,000 managerial positions, alongside ancillary roles (205,000) and regulated professionals (81,000 – *ibid*). The vast majority of jobs (79% or 1.3 million) were in the independent sector, that is, private companies and charities (*ibid*). The next most common employers were direct payment recipients (130,000 or 8%), local authorities (114,000/7%) and the National Health Service (104,000 or 6% - *ibid*). In the care home market, the largest 30 organisations supplied 30% of total capacity, while 29% of care home beds were supplied by providers with one home, who made up 80% of providers in the market (Competition and Markets Authority, 2017). These figures demonstrate the fragmented nature of the adult care sector, which was largely privatised, and dominated by private companies and third sector organisations.

The split of job numbers between different settings is displayed in the table below.

Table 1.1: Numbers of jobs by setting in England, 2020/21

Setting	Number of jobs	Percentage of overall jobs
Domiciliary care	735,000	44%
Residential care	680,000	40%
Community support and outreach	223,000	13%
Day care	38,000	2%

Source: Skills for Care (2021d, p36)

This table shows most jobs were in domiciliary care, with 735,000 in total, followed by 680,000 in residential care. The remaining jobs were divided between community support on one hand, and day care on the other¹. These figures demonstrated that the most common job settings were domiciliary care (referred to in this thesis as 'community care') and residential care.

¹ In reporting its figures, Skills for Care distinguished between different settings using the following terminology: domiciliary care was provided in a person's private home, residential care in care homes with and without nursing, day care was in day centres, and community support and outreach meant social work, carers' support, and occupational or employment-related services (Skills for Care, 2021d, p27)

The importance of the workforce was underlined by its considerable growth in recent years - since 2012/13, the number of jobs in the sector rose by 12% (Skills for Care, 2021d, p29). Due to the demographic trends of an ageing population and more people living with multiple conditions, the workforce was set to continue increasing in size in response to increased demand for services, up to a predicted 2.16 million by 2035 (ibid, p118). The tasks performed by the workforce, sometimes referred to as direct care, could incorporate a range of different services for people with reduced capacity, broadly defined as support, whether mental or physical, relating to chronic health problems, disabilities, and old age. Workers assisted with activities such as bathing, eating, and toileting (Organisation for Economic Co-operation and Development/European Commission, 2013). Such activities, which require physical mobility, were commonly referred to as activities of daily living (Mitchell & Miller, 2008). Some offered more diverse forms of support, such as promoting safety and maintaining a habitable home environment, developing and maintaining personal relationships, and making use of facilities and services in the local community (National Audit Office, 2021). As suggested by a review of the care workforce (Cavendish, 2013), the difficulty of delivering such assistance to older and disabled people with thoroughness and compassion should not be underestimated. Helping an older person to eat and swallow, having meaningful communication with people with dementia, bathing someone with kindness without hurting them, all within a tight schedule – such duties required no little skill, maturity and resilience (ibid). The same review (ibid) found care work was becoming increasingly challenging, with staff having to look after increasingly frail, elderly people, and some domiciliary workers and healthcare assistants taking on roles traditionally held by nurses.

The work performed by care workers and managers, who were often the first point of contact for many members of the public, was crucial to the practice of person-centred care. The same observation applied to another group within the workforce, albeit one existing under different employment structures: personal assistants.

1.6 Self-employed workers/personal assistants

One group of workers who were not covered by CQC regulations, yet made a distinctive contribution to the sector, were personal assistants or self-employed workers. Personal assistants worked closely with clients, either on a self-employed basis or directly for an individual person, usually without any involvement from a care provider organisation. Many local authorities allowed these workers to advertise services on council-hosted websites. People with care and support needs could then search for workers with appropriate skills and backgrounds, and contact them by sending enquiries through the site (see Section 4.3 of Chapter 4 for some examples). Employing personal assistants was not a regulated activity (Hayes et al 2019), therefore the Care Quality Commission did not inspect or monitor this type of care provision. According to the skills council for England, Skills for Care, a personal assistant:

[W]orks directly with the individual they are supporting, in a person-centred way, to enable them to live their life according to their wishes and interests.

(Skills for Care, 2021a, p5)

The wording of the passage suggested the workforce group of personal assistants was earmarked by the skills council as being suited to person-centred care, given the direct relationship between worker and client. Research has suggested this section of the workforce, while relatively small, were favoured by many people as offering more personalised services because they were directly employed by adults requiring support, thereby offering more control over arrangements (Norrie et al., 2021).

Skills for Care (2021d, p46) provided an overview of this group of workers, describing them as employees of direct payment recipients. There were approximately 230,000 adults receiving direct payments (ibid, p15). The same

report said an estimated 100,000 personal assistants in England were carrying out 130,000 jobs working for direct payment recipients (ibid). The average turnover rate of personal assistants in this set of figures was 18.2%, which was lower than the average turnover of 30.5% for direct care roles (Skills for Care, 2021a, p5). It appeared this part of the workforce had a diverse range of experiences. They were typically more experienced in care than regular workers: personal assistants had an average of 8.6 years of experience in the care sector, compared to 6.5 years for care workers in general (Skills for Care, 2021a, p18). In addition, 61% of personal assistants held non-social care qualifications (ibid, p30). This finding could be explained by personal assistants perhaps having left previous careers to work in care. However, there were gaps in the available data: Skills for Care noted their figures only included workers employed by people receiving state-funded direct payments. They did not include those employed privately by adults spending their own money, or accessing funding streams other than direct payments (Skills for Care, 2021a, p15).

The increased level of stability indicated by lower turnover offered by personal assistants, and wide range of experiences possessed by career-changers, implied a high level of suitability for person-centred care. People with care and support needs, choosing to employ assistants, could recruit workers with similar values and interests, on the basis they might form strong relationships with each other. This approach to careful selection of personality and values reflected a recommendation of a government review of Winterbourne View Hospital (Department of Health, 2012c, p54), that providers should recruit based on people's values as well as skills.

Information in this section, along with that in Section 1.5, has introduced some of the key workforce groups involved in the enactment of person-centred care. Together, personal assistants, and provider-employed workers and managers, inhabited the front line of care work, where crucial work of making sense of the concept of person-centred care occurred. Day-to-day responsibilities of many of

these staff involved supporting older people, who are discussed in the next section.

1.7 Older people receiving social care

Older people were the largest client group in terms of individuals receiving local authority-funded care in England. Their needs arose from conditions limiting physical and cognitive functioning that were typically age-related, such as dementia or stroke (Hayes et al., 2019, p6). Although some people in England received financial support from local authorities, generally, care services were not provided free of charge. The most typical routes to receiving care were applying for means-tested funding from local authorities; unpaid care and support from family and friends; and arranging and paying for care privately (National Audit Office, 2021). There were 548,000 people aged 65 or over receiving long-term support arranged by local authorities in 2019/20, compared to 290,000 adults of working age (ibid, p23). Therefore older people constituted 65% of the people receiving state-funded care and support. When it came to those people who paid for care privately, known as self-funders, there was no definitive evidence on the numbers for this category in England (Baxter et al., 2020). However, estimates suggested up to 25% of home care hours and over 40% of care home places were purchased by people funding their own care (ibid). It was assumed older people would have made up a significant proportion of these users. This was because, according to the latest Census statistics for Great Britain, individual wealth was found to have increased with age (Office for National Statistics, 2022).

I noted in Section 1.1 that the signature policy of individualised services – that is, promoting autonomy among people using services under the umbrella of person-centred care - was applied to adults of all age groups in England. Within this policy agenda, direct payments were offered by local authorities to individual people using services to cover the costs of care and support (as

mentioned in Section 1.3). The take-up of direct payments among older people was lower than other age groups. Among people living at home, only 18% of people aged 65 and over received direct payments in England, compared to 40% of younger people with disabilities (Davey, 2021). At the time of writing, direct payments could not be used to fund long-term residential care in England (Department of Health and Social Care, 2020, paragraph 12.47). Given that around half of care home residents in the UK were funded by local authorities (Competition and Markets Authority, 2017), a significant number of people were unable to participate in a high-profile person-centred care policy. Literature has examined the detailed effects of personalised schemes related to direct payments, such as personal and individual budgets, among older people. A qualitative interview study identified mixed responses concerning older people who had been allocated an individual budget (Moran et al., 2013). Data suggested the scheme could have been useful for some older people to help fund short breaks for family carers, or to recruit live-in care assistants with similar cultural backgrounds (ibid). However, several participants said they were worried about the administrative responsibilities of managing the budget, such as employing personal assistants or inadvertently over- or under-spending the budget (ibid). The findings from Moran et al. (2013) were linked to a large-scale evaluation of a pilot programme of individual budgets across different client groups (Glendinning et al., 2008) and drew from the same pool of participants. Glendinning et al (2008) compared outcomes of the intervention among different groups who participated in the study, and found the poorest effects were among older people. Those aged 65 and over experienced lower well-being than the comparison group, while well-being was significantly higher than the control for people with mental health problems (ibid).

Concerns suggested by these findings had implications for the workforce, who may have found disjuncture between the aspirational elements of person-centred policies and the more immediate, day-to-day needs of older people in their care. Older people may have wished to exercise choice and control differently than younger users of services, which raised questions about how

person-centred policies would be conceptualised and implemented in practice with the former group (Lloyd, 2014). One of the methods available to the care sector to prepare the workforce for these challenges was training and development, discussed in the next section.

1.8 Provision of training in adult social care

Training in general was seen as beneficial to the quality of care provided by individual professionals and providers: a workforce with knowledge, skills and qualifications in key areas offered reassurance to clients and their families about workers' confidence and competence (Skills for Care, 2021d). When it came to person-centred practice, learning and development was an integral part of delivering this approach – as noted in Section 1.1 (see discussion of McCormack & McCance, 2006). For most staff, training was provided by employers in the care sector, alongside a supervisory role of local authorities. The infrastructure for skills and practice development in England and challenges surrounding its provision are discussed from a critical perspective here.

Employers played a significant part in the provision of training and qualifications for care staff. Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014), titled 'fit and proper persons employed', outlined key responsibilities in this area. It said all persons employed to carry out care duties must be 'of good character', and 'have the qualifications, competence, skills and experience which are necessary for the work to be performed by them' (ibid). Responsibility for meeting this standard rested with employers in their role as recruiters and trainers. Employers had a duty to ensure workers received adequate training, supervision, and appraisal (Hayes et al., 2019). The mixed economy of care providers in England meant that training provision was spread across several different types of organisations. It was either delivered by employers themselves, or through external providers such as private

companies, charities or not-for-profit organisations, and educational institutions (Thomson et al., 2018, p15). Meanwhile, responsibility for ensuring personal assistants had suitable qualifications and experience lay with the worker themselves and their employer (Skills for Care, 2021a). The way such decision-making was delegated to localised parties such as care managers and even workers themselves reflected the decentralised nature of the care sector, in a reflection of the principles of the Localism Act, noted in Section 1.3.

The policy intention was that provision would be complemented by support from local authorities. Statutory guidance on care (Department of Health and Social Care, 2020) stated local authorities should encourage training and development of staff (according to their status of employers and service commissioners). However, in reality, there was a heavy reliance on care providers to determine what constituted appropriate training and supervision (Hayes et al., 2019). Expectations on employers and individual workers to invest and engage in training and development were complicated by the way the care sector was regulated. As stated in Section 1.1, care workers in England had no system of professional registration. Accordingly, there were no requirements to have any qualifications before starting a care job (ibid). Employing a personal assistant to provide social care was not a regulated activity (ibid), therefore there were no rules about training people in this group. Perhaps due to the absence of legal requirements in this area, there were inconsistencies in the take-up of training. Estimates suggested only 44% of the overall care workforce in England had a social care qualification (Skills for Care, 2021d), while among personal assistants, the figure was lower at 37% (Skills for Care, 2021a). As shown in Section 1.4, the Care Certificate included standards on person-centred care, acting as a key mechanism to disseminate messages about the concept. However, according to a recent estimate, only 45% of the total adult social care workforce had achieved or were working towards achievement of the Care Certificate, while the majority (55%) had not started or were not engaged with the programme (Skills for Care, 2021d). The same workforce review (ibid, p110) described the ten most common topics of qualifications completed by the

workforce, which included moving and handling, safeguarding, infection control, fire safety, first aid, and food safety. Person-centred care was not mentioned (ibid).

The inconsistencies in training provision may have been explained by systemic weaknesses in the sector. Statutory guidance (Department of Health and Social Care, 2020) recommended that local authorities support training of the care workforce. However, in practice, councils lacked strategic ability to require providers to offer training, so provision of skills development varied depending on the employer (National Audit Office, 2018). Providers and commissioners blamed funding constraints for difficulties in offering more extensive training programmes, as they needed to prioritise the delivery of care (ibid). Indeed, literature suggested that skills development in social care received less funding compared to other public service professions. The care workforce in England was bigger than that of the National Health Service, yet received less government funding for training (Hayes et al., 2019). A group of MPs with common interest in the sector, the All-Party Parliamentary Group on Social Care, produced a report on the workforce exploring these issues. The report (All-Party Parliamentary Group on Social Care, 2019) cited figures suggesting the social care workforce received a typical training budget of £16 per head per year, compared with £3,615 per head per year for the National Health Service. The shortfall was exacerbated by a high turnover rate in the sector. Turnover in the adult social care sector in England across all roles was estimated to be 29% in 2020/21, with 31% for direct care roles (Skills for Care, 2021d). The latter rate was more than double the average turnover across the economy in England, estimated at 15% (National Audit Office 2018, p18). As a result, skill levels of remaining workforce members in social care could have been diluted: employers might have been less willing to invest in staff training if some employees would be leaving soon anyway (Thomson et al., 2018, p15).

Inconsistencies in training provision were problematic for the delivery of person-centred care, as research has suggested staff training in person-centred

approaches can contribute to positive outcomes for people receiving care (Chenoweth et al., 2009). It has been argued that adopting a style of care framed around the needs of individual people required substantial commitment on staff to reflect and develop their own practice (McCormack & McCance, 2006). A recent empirical study about skills development involved interviews with nursing home managers about the implementation of a workforce intervention aimed at person-centred dementia care (Barbosa et al., 2017). The findings suggested care assistants participating in the programme were closed-minded and resistant to change, which, according to the managers, was a barrier to the effective implementation of a person-centred programme for people with dementia (ibid). However, other commentators have suggested formalised training alone would not be a panacea. In any case, problems within standardised training may have been compensated for by a culture of on-the-job training in adult care (Hayes et al., 2019). The transfer of practical knowledge and capabilities from one care worker to another was a prominent feature in the sector, yet such learning received little attention in literature (ibid).

Observations from literature in this section have pointed to weaknesses in the provision of training and development for care staff in England. The decentralised nature of the care sector meant that responsibilities for planning and delivering training were often left to individual employers and private companies. The fact that person-centred care was not in the top ten topics of workforce training was surprising, given the prominence of the concept in long-term care policy. This and the low take-up of the Care Certificate indicated an absence of any widely accepted model of practice relating to person-centred care in England. The role of interpreting high-order principles relating to personhood and individuality, linked to Regulation 9 of the social care standards for England (see Section 1.4), appeared to be devolved to local settings and professionals inhabiting the front line of care.

I noted in Section 1.1 that high standards of care for sick and older people were a mark of decency in any society. Given the vital part played by care workers in

upholding such standards, and, by extension, decency, one would expect this workforce to be treated with due respect. The jarring dissonance between this expectation and actual conditions on the front line are discussed below.

1.9 Marginalisation of care workers in social policy and society

Policy-makers have often championed the skills and professionalism of care workers. The government acknowledged the importance of the workforce in statutory guidance, which said care staff can have a significant effect on the well-being of adults receiving care (Department of Health and Social Care, 2020, paragraph 4.21). Individual politicians have echoed this point. For example, the Secretary of State for Health and Social Care, Matt Hancock, paid tribute to the ‘amazing efforts’ by the UK’s care workforce during the COVID-19 pandemic in a televised news briefing (ITV News, 2020). Hancock praised ‘the tenderness and dedication with which people in social care support our loved ones’ (ibid). In the same news briefing, the minister announced his support for a lapel badge for the care workforce – a so-called ‘badge of honour’ (ibid). The badge, a national initiative devised by Care England (National Care Forum 2019), was to be distributed to care workers across the country, with the word ‘care’ in capital letters positioned against a green background (Department of Health and Social Care, 2021a). Care services minister Helen Whately told Parliament giving badges to care workers would heighten their visibility and give the workforce a bigger voice (Whately, 2021). At the time of writing, it was not clear whether the badges were still available for care workers to obtain.

Image 1.2: Green badge distributed to care workers in England, worn by the author



Some within the care sector welcomed the scheme as a way of raising the profile of care workers (Politics Home, 2020). However, the badge was criticised as a hollow gesture that did not address fundamental problems such as low pay and poor conditions affecting the workforce (Wood & Skeggs, 2020).

As noted in Section 1.5, care workers were one of the biggest sectors in terms of employee numbers in the wider economy and provided essential services to vulnerable people. Yet warm words of praise from politicians did not extend to improving stagnating employment conditions on the front line of the care sector. Indeed, the UK government was criticised for failing to meet commitments to improve workforce training and recruitment over several years (National Audit Office, 2018). The group has been consistently undervalued in society and poorly rewarded (ibid, p11), as noted in Section 1.1. Nowhere was the low value of care work more strongly symbolised than pay rates. At the time of writing, care work was one of the lowest-paid jobs in the economy, lower than shop workers, albeit slightly higher than kitchen and catering assistants (Skills for Care, 2021d). As of 2020/21, staff in the independent sector were paid a mean hourly rate of £9.29, just above the mandatory national living wage for workers aged 23 and above, of £8.91 (ibid). For personal assistants it was a slightly higher rate of £9.95 an hour. In the same period, the mean wage for workers in domiciliary care was £9.44 per hour, with £10.04 for senior workers (Skills for Care, 2021f), while staff in residential care received £9.05 per hour and £9.95 for senior staff (Skills for Care, 2021e). In recent years, wage increases for the

sector were among the lowest in the economy (Low Pay Commission, 2020). Analysis by the Institute for Public Policy Research (2018) found 25,000 care workers in the UK were being paid below the minimum wage, in breach of employment law. Rates paid by local authorities for all types of care failed to match increases in the national living wage (Low Pay Commission, 2020, p130). The mismatch between the level of pay and demands of the job was exacerbated by a lack of bargaining power among workers. According to the Institute for Public Policy Research (2018), only around 20% of care workers were members of trade unions or staff associations, allowing employers to set pay according to their needs. This low level of representation added to the sense of marginalisation among workers. A report on the social care workforce by a Parliamentary committee concluded that 'care work does not attract the pay that it should for a skilled occupation' (House of Commons Committee of Public Accounts, 2018, p14).

The impact of such poor conditions has been detrimental to recruitment and retention (Institute for Public Policy Research, 2018, p13). The National Audit Office found low pay for care workers was contributing to high vacancy and turnover rates, and care work was viewed by the public as low-skilled with limited opportunities for career progression (2018, p7). The high level of churn in the workforce may have created obstacles for building the strong client-worker relationships that some viewed as integral to person-centred care.

Pressure on the care sector was exacerbated by the COVID-19 pandemic, which led the government to order all care homes in England to close doors to visitors in March 2020. Providers of residential and domiciliary care implemented widespread infection control measures. Rules were relaxed in July 2021 and replaced by guidance on visits, hygiene, social distancing and testing instead (Department of Health and Social Care, 2022). There was a shortage of personal protective equipment (PPE) for care workers in England during the pandemic, which created difficulties for staff in domiciliary and residential settings (Nyashanu et al., 2020). During the COVID-19 pandemic in England,

an online seminar was organised by Birkbeck University to discuss the experiences of the care workforce. One care worker from London, Caroline Weimer (2020), said some staff had to pay for their own PPE.

When this pandemic started...not once was I asked about, 'Do I need any extra time for clients because I might have to get their shopping?' You know, the queues that were in the supermarket, the queues that were in the chemist for their medication, I was never asked, were there any health issues that I had, did I feel safe going into clients with the health issues that I might have had, what about the health issues that they might have had. There was no contact. I was actually left to my own devices.
(ibid)

The lack of contact by employers or authorities, described by Weimer, projected a sense of abandonment felt by staff in this time of crisis. Such feelings of marginalisation were reflected in an under-representation of care workers in public policy. Their voices were often absent from policy debates in the UK (Hayes, 2017; Imison & Bohmer, 2013). One example was identified in a care and support white paper, which cemented the government's commitment to personalised services. In announcing these reforms to the care sector, ministers promised to listen to the voices of people using care and support, 'their carers', and relatives and friends as legislation was carried forward (HM Government, 2012, p3). There was no mention of care workers ('carers' referred to unpaid or informal carers, as opposed to professional workers). Elsewhere, the Department of Health (Department of Health, 2014b) held consultations about reforming Care Quality Commission guidance, which led to the introduction of 'person-centred care' as one of the fundamental standards for providers (Care Quality Commission, 2014). A list of respondents included employer bodies, such as the Association of Directors of Adult Social Services and Registered Care Providers Association, and organisations representing service users, such as MIND, the Relatives and Residents Association and Alzheimer's Society (Department of Health, 2014b). There were no organisations representing care professionals. Skills for Care, the sector skills council, has been criticised for

lacking representatives of care workers at board level, and for leaning too heavily on the advice of provider representatives (Kingsmill, 2014). The organisation's website suggested that, at the time of writing, the board was led by several heads of provider organisations and one advocate for people with disabilities, with still no worker representatives (Skills for Care, 2022b). These omissions were surprising, given the wealth of practical experience staff would have been able to share, and the localised knowledge about the shaping of services around individual people, which could then have been used to improve policy. The repeated exclusions may have contributed to a sense of front-line workers feeling marginalised, viewed as inferior participants in the labour market (Hayes, 2017).

A government-sponsored review of the national care workforce concluded more was being demanded of individual workers during the shift towards person-centred care (Cavendish, 2013, p24). Such demands were instigated at a time when wage increases were sluggish. In this fragmented, decentralised sector, where the voices of front-line workers held little sway, greater responsibility for empowering clients was being shifted towards care staff in these sweeping reforms with scant consultation and little reward. In addition, throughout the government's series of reforms, one would have thought it logical to stabilise the care sector's infrastructure, which commentators believed was crucial for effective, person-centred care – for example, by encouraging more employers to invest in training and supervision. Yet the fragmented nature of the sector undermined policy-makers' ability to improve recruitment and other aspects of workforce development. For example, local authorities commissioned most care from independent providers, many of which were autonomous businesses; such businesses may have made decisions regarding employment conditions for commercial reasons that were inconsistent with the objectives of the government or local authorities (National Audit Office, 2018). Taking such challenges into account, the All-Party Parliamentary Group on Social Care concluded the workforce was in 'crisis' and called for the development of a national strategy to improve it (2019, p11). Under-investment in the sector has

been identified as the most significant barrier to delivering person-centred care (Beresford et al., 2011, p67-68). Studies have shown front-line care staff frequently lacked time to engage properly with clients, with heavy workloads inhibiting chances to implement person-centred practice (Kadri et al., 2018; Watson, 2019).

To summarise, one commentator suggested community care workers were 'pretty much the lowest valued group of workers in the UK' (Hayes, 2017, p11). Given that residential workers received less pay than community care workers in 2020/21 in England and were also routinely excluded from policy debate and consultation, I would argue Hayes' description held equally for care staff across all settings.

1.10 Critique of person-centred care policy

Key pieces of legislation described in Section 1.3 (the Community Care (Direct Payments) Act 1996; Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014; and Care Act, 2014) established person-centredness as a high-order, yet ambiguous, policy objective permeating the sector. Despite inadequacies in provision of training for staff and the marginalisation of workers, described in Sections 1.8 and 1.9, policy-makers pressed ahead with sweeping reforms contained within this legislation, ostensibly aimed at making the sector in England more individualised. Expectations on professionals to implement these policies were set out in guidelines, introduced in Section 1.4. Building on the discussion of training provision in the previous section, these guidance documents will be examined from a critical perspective here. The section will also consider the interpolation of one the key client groups within adult social care - older people – within such reforms.

Section 1.3 outlined key events which preceded the major reforms of the 2010s, damaging the reputation of health and social care in England. Under pressure

to respond to these scandals, policy-makers embarked on a series of reforms, crafting persuasive narratives which implied personalised care would have a transformative effect on the care sector and on people's lives. What transpired was an incongruous blend of heavy regulation of employers and light-touch regulation of the workforce. The principles on which the fundamental standards for all care services were based (Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014), described in Section 1.4, included person-centred care as a central objective. The definition of person-centred care contained within these policy documents – centring around a highly subjective adjective to describe the style of care, 'appropriate' (ibid) - was brief and opaque. A similar sense of ambiguity was found in Care Quality Commission guidance, containing information for providers on complying with standards (Care Quality Commission, 2015b, p28). As noted in Section 1.4, this document urged providers to do 'everything reasonably practicable' to make sure care was appropriate, under the information for Regulation 9, 'person-centred care' (ibid). The vagueness of this passage did little to illuminate the original definition of person-centred care in the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014). A sense of uncertainty was attached to phrases such as the need to provide care reflecting the person's preferences, 'whatever they might be', and the instruction to do 'everything reasonably practicable' (ibid). The guidance was open-ended, requiring interpretation among individual workers and managers as to how exactly compliance should be carried out.

The workforce standards, introduced in Section 1.4, were couched in ambiguous, aspirational language. They defined person-centred care with values-laden terminology, such as individuality and choice. There was a running theme of maintaining client independence, noticeable in the descriptions of person-centred care within the Care Certificate (Skills for Care, 2015), Diploma materials (Skills for Care, 2016a), and guidance from the National Institute for Health and Care Excellence (2015). This principle reflected a common theme of autonomy and independence within international equality treaties and legislation, such as the Convention on the Rights of Persons with Disabilities

(United Nations, 2006), discussed in Section 1.2. However, this apparent provenance was not made explicit. Beyond this commonality, meaning appeared to fragment and diverge among different documents. There were eight aspirational principles in the Care Certificate definition of person-centred care (Skills for Care, 2015), and 13 in the Diploma definition (Skills for Care, 2016a). The discrepancy between the two definitions was not explained, despite both programmes being overseen by the same skills council, Skills for Care. There was further incoherence in the inclusion of related qualities of person-centred care in the Diploma definition (*ibid*) of ‘compassion’, ‘communication’ and ‘competence’. These could equally have applied to alternative approaches to care, which, instead of person-centredness, focused on, say, professionalism or consistency. A sense of ambiguity was implied by the Care Certificate definition (Skills for Care, 2015) and that within the national Diploma materials for care workers (Skills for Care, 2016a). Both featured the word ‘including’ when describing the typical values considered relevant to person-centred care. This caveat implied the list might not be exhaustive. These terminological variations and ambiguities supported a finding from academic literature, that there was little consensus on the meaning of person-centred care (Håkansson Eklund et al., 2019).

The materials for the Diploma programme (Skills for Care, 2016a) suggested workers ‘take into account’ detailed information about the individual client’s history and preferences in their care. The question of how this process of ‘taking into account’ might be performed was left hanging, but seemed to imply some level of imagination or creative practice on the part of care staff. The empirical foundation for these ‘official’ definitions was unclear. This lack of clarity reflected a criticism of literature espousing the virtues of person-centred care, which found that while it may have made sense, it was often difficult to ascertain the empirical material on which definitions were based (Edvardsson et al., 2010). In addition, the looseness of these descriptions appeared to illustrate the elasticity of the concept’s meaning, and the way in which person-centred care was often, and sometimes superficially, bound up in ideas around good practice or high-

quality care (Manthorpe & Samsi, 2016). The presentation of the definitions – in bullet-pointed lists of complex values - had the unfortunate effect of resembling a laundry list of desirable outcomes, without clear explanation of why they were important or how they could be realised. This ambiguous style of presentation represented a trend in policy documents, which regularly referred to ‘person-centred’ approaches without defining what these meant in practice (Symonds et al., 2019).

There was an unspoken assumption that responsibility for interpreting these subjective policy goals was devolved to employers and care workers, who relied on individual discretion and judgement to make sense of opaque practice guidance (Morgan, 2019). It appeared the problems of complex, confusing guidance on adult social care, highlighted by the Law Commission (2011), as noted in Section 1.3, had not been remedied by government reforms. The report found that language used in statutory guidance was ‘often too vague to be instructive and contains policy exhortations rather than legal guidance’, which could cause confusion among practitioners (ibid, p13). This observation continued to stand, in my view, even after the reforms enacted by government which led to the Care Certificate and fundamental standards. The lack of substantive, accessible definitions to help inform practice for workers and managers on applying person-centred values in practice was problematic, given the crucial role of these actors in delivering care, and seemingly at odds with the importance placed on person-centred approaches as a central regulatory objective.

It was notable that, as stated in Section 1.6, the skills council for England, Skills for Care, admitted it did not collect data on self-employed workers or those employed privately by clients. This oversight rendered an increasingly important part of the workforce practically invisible in policy terms. Given the likelihood of these staff offering more stable and arguably more personalised care services, this was a notable and potentially damaging gap in evidence. As the UK government admitted, it relied on data about the social care sector from public

institutions, such as local authorities (Department of Health and Social Care, 2021b). The resulting gaps in information may have impacted on the way policy decisions were made and affected the government's response to emerging issues and risks (ibid).

The combined weight of regulations from these sector bodies set expectations for adults of all age groups to receive person-centred care. As mentioned in Sections 1.1 and 1.2, proponents of personalised services argued there was inherent value in empowering adults requiring care and support to make decisions, citing research showing links to improved well-being among clients. One of the chief mechanisms of personalised support was direct payments, as noted in Section 1.3. The primary legislation for this policy, the Community Care (Direct Payments) Act (1996), limited availability to adults under the age of 65. Older people could not apply for direct payments until the law was changed four years later – they seemed to be an afterthought in the context of these policy reforms. The disparity reinforced an observation by Barnes (2011) that the adult care system was designed around the needs of younger adults, willing and able to make decisions about their care. Questions remained about whether older people wanted to choose and plan their own care and support (Lewis & West, 2014). People whose health was in severe decline, or those who lacked capacity through dementia, may not have been able to fulfil necessary prerequisites for greater independence (Woolham et al., 2017), and may have valued strong relationships with practitioners more than autonomy over services (Wilberforce et al., 2017). Another critique suggested person-centred policy amounted to little more than consumerism for health and social care, as promotion of autonomy based on individualism would be untenable for older people (Nolan et al., 2004). Section 1.3 quoted from a minister's speech to Parliament about the government's vision of person-centred care. The minister referred to 'other individuals' who would require 'a high level of support' to exercise decision-making capacity (Lewis, 2008). The paradoxical argument that some clients needed high levels of support to become independent was an example of the type of convoluted thinking by policy-makers in this area to

which commentators had become accustomed. It was argued that complexity was an inherent feature of the care policy landscape in England (Morgan, 2019). In an ironic contradiction of pro-choice arguments, it appeared older people were being subjected to the same 'one-size-fits-all' mindset person-centredness intended to negate.

These were some of the challenges of the task of making older people's services more person-centred. Revised regulations for the sector in England required care professionals to absorb and interpret convoluted, values-based guidance relating to person-centredness, sometimes with little training and experience. Some of these values, such as the emphasis on independence and autonomy, appeared to reflect core principles of treaties such as the Convention on the Rights of Persons with Disabilities (United Nations, 2006). This strategy could have been explained by the UK government's commitment to uphold the principles of a convention it had previously ratified. However, the ambiguity of policy guidance made the task of delivering individualised approaches more challenging. Like other public service workers in decentralised sectors, care workers and managers faced criticism for possibly taking one approach over another (Brodkin, 2007). The focus on person-centred care in this manner was an example of the promotion of grand rhetorical ambitions by policy-makers, where delivery of contentious specifics was frequently devolved to front-line professionals (*ibid*).

1.11 Concluding comments

This chapter has presented a picture of the front line of care in England and its complex governance landscape, where practical translation of an ambiguous, values-laden policy took place. Care workers were an increasingly important group in health and social care services, frequently operating as the first point of contact with the care sector for many members of the public. Politicians praised their 'amazing' work (see Section 1.9). Yet, as this chapter has argued, these

staff were routinely subjected to marginalisation. The views of care professionals – and those of an unregulated and seldom-discussed group: personal assistants - were rarely sought in reforms that held critical implications for their role. An under-funded infrastructure surrounding the workforce continued to creak, suggesting these tributes – including the government’s ridiculed ‘badge of honour’ scheme – amounted to little more than lip service. Yet policy-makers pressed ahead with individualised programmes across adults of all age groups with relentless enthusiasm. Attempts to respect the personhood and individuality of clients have become a policy mantra. However, the meaning of these concepts had become intangible, buried within ambiguous definitions and bullet-points listing abstract principles. The astute observation from the Law Commission (2011), noted in Section 1.10, that language used in statutory care guidance for England resembled policy exhortations rather than concrete advice, continued to resonate even after the reforms of the 2010s.

And so it was front-line professionals who had to make sense of high-minded, rhetorical objectives linked to person-centred care, such as promoting ‘independence’ and ‘individuality’ (Skills for Care, 2015) in day-to-day care work with older people. The ambiguity of policy guidance demanded reflexive skill, to transcend the menial side of care and support and see the unique facets of the person being supported. To gain further insight into the conceptual meaning, it would be instructive to consider the origins of personhood and person-centred care, which have been the subject of substantial exploration in academic literature.

Chapter 2: **Person-centred care: theory, operationalisation and practice**

2.1 Introduction

Chapter 1 introduced a series of individualist policies which have shaped today's care system in England. In a parallel body of literature, the interpolation of person-centred approaches into the care and support of adults found itself at the centre of contentious debate. On one hand, scholars have praised its contribution to civil society and for grounding policies in core aims of citizenship and social justice. On another, critics have suggested the 'person-centred' label amounted to little more than an attractive-sounding political slogan to identify a user-oriented approach to aged care (Edvardsson et al., 2010). In addition to diverse opinions about the merits of the concept, commentators have been divided on the rationale behind these policies. Arguments have framed person-centred care as variously: a rejection of institutionalised, 'one-size-fits-all' approaches to welfare seen in the earlier 20th century (Cutler et al., 2007); an attempt to keep pace with public expectations on user involvement with decision-making in services (Baxter et al., 2008); a response to perceived failings of other good-practice models such as outsourcing and managerialism (Needham, 2011b); and a cost-effective solution to meet the needs of growing numbers of people with long-term conditions (Manthorpe & Samsi, 2016). Just as the policy's provenance remained unclear, a single, shared meaning of person-centred care was equally elusive (Needham, 2013). Many scholars were in agreement, however, on the theoretical contribution of two key authors from the field of psychology in formulating the concept of person-centred care: Carl Rogers and Thomas Kitwood. This recognition stands even if today's policies described as person-centred approaches - as this chapter will argue - have

drifted from the term's philosophical origins. This chapter will present key points of Rogers' and Kitwood's theories, a description of efforts to aid implementation of the concept with good-practice frameworks, and a discussion of contested ways in which person-centred interventions have been operationalised and evaluated in literature. It moves on to offer a critique of literature and discuss the impact of an enduring ambiguity about the meaning of person-centred care, before describing the rationale behind the research project and its aims and objectives.

2.2 Rogers and client-centred therapy

Influential scholars in person-centred theory shared a common interest in challenging the conventional thinking of the day. The American psychotherapist, Carl Rogers, who began publishing influential books and articles in the 1950s, was no different in this respect. Rogers attempted to stimulate creative practice in mental health by promoting strong relationships between clients and professionals, built on mutual warmth, trust and respect. His model of 'client-centred therapy' reasoned that the client had capacity to understand problems in their life. The therapist's role was to foster an atmosphere of acceptance and understanding, allowing the client to realise their inner agency and strengths (Rogers, 1952). Client-centred therapy questioned the hierarchical power structures in the therapeutic field, where professionals made the majority of decisions and judgements while maintaining emotional distance from the client. Instead, the client was seen as an expert on their own life. The therapist sought to learn about the unique qualities of each client by providing an empathetic presence, supporting the person to become more reflexive in their outlook. Empathy was seen as one of the most useful tools for professionals, whose aim was to enter the 'private perceptual world of the other and [become] thoroughly at home in it' (Rogers, 1980, p142). Rogerian theory was grounded in the notion of the 'actualising tendency' of human life: a universal motivation in which, given the correct social and environmental conditions, people would flourish and

determine their own path in life (Murphy et al., 2012). According to Rogers, therapists should seek to understand the client's perceptual frame of reference and accept the validity of their experience. The client would then be encouraged to pursue their aspirations, to grow as a person, and organise and direct their own future (Rogers, 2003).

Rogers' legacy was in his model of client-centred therapy becoming utilised in a substantive reimagining of long-term care for adults towards the end of the 20th century. A body of literature developed with discussions of the application of Rogerian principles to long-term care. For example, social care professionals attempting to adopt this style have tried to nurture strong, therapeutic relationships with clients, based on sincerity and unconditional positive regard towards the person (Murphy et al., 2012). One influential author, a fellow psychologist, Thomas Kitwood, built on the ideas of Rogers with a revised vision of personhood that would become an integral aspect of the philosophical fabric of long-term care.

2.3 Kitwood's theory of personhood and related literature in 1990s

Development of the concept of person-centredness in adult care and support has been largely attributed to the social psychologist, Thomas Kitwood. His ground-breaking research in dementia care was influenced by Rogerian psychotherapy and its emphasis on authentic contact and communication (Brooker & Latham, 2015, p16). Kitwood's pioneering work was presented in a series of books and articles in the 1980s and 1990s. Like Rogers, the author wished to challenge conventional practices. Driven by moral outrage at apparent failings and prejudices of institutionalised care, Kitwood attempted to redefine standard practice in dementia care. Chief among his interests was to reverse the social exclusion of people with severe illness and disability. Such treatment was caused by entrenched ageism, he argued, which treated older people, especially those with cognitive impairment, as incompetent, senile, and

burdensome (Kitwood, 1997, p12). The received wisdom of care practice at the time was influenced by a biomedical model of ageing, which viewed dementia as a group of neurological illnesses and related symptoms. In this outdated model, professionals viewed confusion and agitation as inevitable symptoms of the illness; decline was progressive and irreversible. The self was treated as irretrievably lost when severe cognitive impairment took hold; as a result, people's social and psychological needs were neglected by the care sector (ibid, p69).

Kitwood was interested in social psychology – that is, a branch of psychology focusing on features of social behaviour, such as interactions and group dynamics (Colman, 2015). Kitwood felt former attitudes stemmed from a fundamental ignorance of the links between social psychology and a person's quality of life. While the author accepted cognitive performance was partly neurological, he argued it was also epigenetic: that is, shaped by a person's life experience (ibid, p18). As an alternative, he proposed a theory of personhood, which, he argued, should inform approaches to dementia care. Kitwood viewed personhood as constructed from a combination of unique characteristics belonging to each person, such as gender, culture, lifestyle, beliefs, and values - usually discernible for many people at a surface level. When supporting people with severe cognitive impairment, however, Kitwood argued a deeper understanding of the inner self was required. The author defined personhood as follows:

It is a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust.

Kitwood (1997, p8)

This passage illustrated a defining assumption of Kitwood's theory, overlapping with principles of Christian philosophy: each person was inherently worthy of respect, prompted by ethical and moral concern for others (Dewing, 2008). This

was because all people, regardless of age, ability, or impairment, retained their status as sentient beings (Kitwood, 1990, p185).

As stated in Section 2.2, Rogers' vision of client-centred therapy assumed individuals had capacity to grow, develop, and become self-sufficient (Kramer, 1995). Kitwood's model was intended to encourage care built around the positive social psychology he believed was crucial to quality of life (Kitwood, 1997, p67). The aims of Kitwood's theory, in contrast to Rogerian practices, were to offset deterioration of cognitive functioning and erosion of the self, normally attributed to dementia (ibid). The differing objectives may have been attributed to the client group in which the respective authors specialised. Rogers worked as a psychotherapist and wrote of young adults (1950, p447), with whom he worked, who were presumably of sound mental capacity. By contrast, Kitwood (1993, p52) focused on people of advanced age and levels of cognitive impairment, in the context of a 'vast increase of the prevalence of dementia'. Partly in response to these demographic trends, literature on person-centred care in the 1990s, driven by Kitwood and colleagues, attempted to develop a ground-breaking model of dementia care. The person-centred method proposed a relationship between the quality of interactive processes within care settings and people's well-being, as part of a wider critique of what scholars viewed as institutionalised apathy towards dementia.

Amid this emphasis on social psychology, Kitwood highlighted the importance of professionals offering 'positive person work' to their clients (Kitwood, 1997, p119). Skills such as observation, recognition, negotiation, and collaboration, were required; activities such as reminiscence work could be an effective means of tapping into a person's long-term memory, which typically remained intact (ibid). However, the care-giver's first task was simply to be present and 'psychologically available' (ibid). The onus was on the professional to understand the person's frame of reference (Kitwood, 1990, p184), in all its eccentricities. The active respecting of personhood during care work demanded a strongly empathetic approach, which could only be achieved through high

levels of reflexivity and self-awareness on the part of the professional (Kitwood, 1997, p131). The effectiveness of positive person work could be judged by outcomes noticeable within the client themselves: specifically, renewed self-esteem, agency, social confidence, and hope (Kitwood, 1993, p66).

Kitwood and Bredin (1992) raised the importance of interpersonal milieu, relationships, and interdependence among older people. The authors proposed indicators of the well-being of people with dementia, such as the ability to express emotions, and initiation of social contact, after studying data based on many hours of observations of 'dementia sufferers in a variety of settings' (ibid, p280). In a subsequent article, Kitwood (1993) developed these ideas by presenting a model of communication between professionals and people with dementia. The author illustrated the model with a series of vignettes, apparently based on incidents observed by the author in a day centre and two different residential homes (ibid, p59), offering positive anecdotal descriptions of exchanges between professionals and residents. Kitwood's research methods appeared to draw on qualitative tradition, although methods used to collect and record evidence were not described (ibid). Kitwood also discussed the outcomes of people with dementia when person-centred care was applied by professionals. Some people were said to have recovered social skills, independence and continence, and improved social relationships (Kitwood & Bredin, 1992), in a phenomenon known as 'rementia'.

Sixsmith et al. (1993) explored the possibility for rementia through a more clearly structured study of a person-centred initiative for older people with cognitive impairment. This project tracked changes in care home residents using a standardised instrument to study behaviour, involving residents of three care homes over a period of months (ibid). The design was intended to measure changes in residents' dependency and the impact of person-centred care on physical and mental functioning (ibid). The authors concluded that 'the data do provide support to the rementia hypothesis', that 'tangible results are possible and the potential for dementia care goes well beyond the limited scope

implied by the biomedical model' (ibid, p998). However, this conclusion was confusing given that elsewhere, the article stated in the majority of participants, functioning was not improved by the intervention (ibid, p997). Nevertheless, the research design of Sixsmith et al's study was telling. The author's choice of variables assumed person-centred care might be capable of altering certain outcomes of people using services – in this case, outcomes centring around the functioning of older people.

Kitwood's ground-breaking theories have been attributed to a surge of initiatives aimed at developing person-centred care and improving societal attitudes towards people with dementia (Manthorpe & Samsi, 2016), and debates on the importance of personhood in adult services (Ryan et al., 2008). The rise of person-centred care as a policy and practice concept has led to some strong, critical responses in academic literature, however. These are discussed next.

2.4 Contentious debates surrounding person-centred care

Person-centred care generated a wide range of appraisal as it developed into a key policy foundation for England's long-term care sector. At one end of the critical spectrum, the idea of shaping services around individual circumstance and need attracted many supporters in the third sector and academic world. Many of these supporters acted simultaneously as advocates for older and disabled adults. Policy reforms were appropriated in these quarters because they appeared to shift focus onto the needs of such people who had previously found themselves marginalised by sprawling systems (Beresford et al., 2011). One of the key proponents of this era, Duffy, felt the shift would usher in a new era of citizenship in civil society (Duffy, 2010a). This author in particular showed strong willingness to align himself with statements from policy-makers. As mentioned in Section 1.3 of Chapter 1, Duffy (2011) cited positive testimonies originating from a politician about the life-changing properties of person-centred care. Meanwhile person-centredness opened up exciting opportunities for

innovation, according to other researchers. The model offered a refreshing combination of practice wisdom of front-line professionals and lived experience of people using services, according to another group of authors (Glasby & Littlechild, 2009).

A set of opposing viewpoints emerged from a group of more critical commentators, who queried claims that the vast reach of individualist policies would transform the care sector for the good. One group of authors questioned whether the idea in its current policy manifestation was a 'panacea' for health and social care (Nolan et al., 2004). Critics said the framing of the concept was problematic on two fronts. Firstly, it was alleged that proponents of person-centred care were too preoccupied with the positive results of evaluations, and tended to overlook negative findings. There were concerns that improvements to services for older people delivered by person-centredness were not matched by 'exaggerated' claims to universal superiority (Spicker, 2013, p1272). Spicker (ibid) noted some allegedly specious claims and rhetorical devices used in policy arguments to justify claims in favour of personalised ideas. One policy text involved a circular argument regarding the cost-effectiveness of personalisation (ibid, p1270), while another involved a 'leap of faith' about the benefits of empowerment, with no basis or evidence on which to evaluate the argument (ibid, p1262). Meanwhile, another group of commentators questioned the 'evangelical zeal' with which the concept was advanced, arguing the more often its virtues were espoused, the less clear its meaning became (Wilberforce 2017, 87).

This criticism leads to the second area of contention, that the mutability of the concept's definition allowed it (the meaning of person-centred care) to become distorted and confused. While politicians claimed they were promoting social justice principles under the guise of choice and control in health and social care, they may have been simply constructing a consumerist or commercialised policy which suited vested interests in the policy-making arena (Nolan et al., 2004). The infiltration of marketisation associated with person-centred services

may have inadvertently led to the overlooking of wider social and political circumstances in which care needs arose (O'Rourke, 2014). Ferguson (2012) had a similarly sceptical approach to the idea that person-centred approaches were truly aligned with social justice ends, in a direct response to Duffy's argument. The vagueness of the concept, according to Ferguson, undermined its usefulness as it could be co-opted by powerful actors whose views towards social justice were different to those shared by Duffy and other campaigners (ibid). Any true meaning of personalised care was therefore unattainable, in the same way a true meaning of empowerment or participation was difficult to ascertain (ibid).

These examples of commentary have illustrated some of the schools of thought emerging in recent decades in relation to developing practices of person-centred care. They have shown that the commentary sometimes included sharp critique on different sides of the argument. Debate in this contested area continued on several fronts. The next section will consider varying ways in which the concept has been framed and operationalised.

2.5 Post-Kitwood attempts to define and operationalise person-centred care

In addition to critical commentary on policy and practice, a substantial amount of theoretical and evaluation literature has emerged. Evaluation reports commissioned by government ministers and charities, and discursive studies in journal articles have tested the concept of person-centredness from different angles, often in minute detail. In many cases, producers of research pre-defined the parameters of studies – for example, by specifying outcome variables to be examined among participants. These research design choices had implications for the hermeneutic impressions of person-centred care created in the minds of readers, which will be elaborated on below. This body of literature has produced distinctive and, in some cases, conflicting findings. These conflicts have

contributed to a sense of conceptual malleability surrounding the meaning of person-centred care, and the original vision of personhood proposed by psychological experts, Rogers and Kitwood, becoming diluted and even distorted - as argued by Ferguson (2012). This discussion of operationalisation offers context to the development of practice models, which would be used to inform the implementation of person-centred approaches with adult clients in front-line settings.

The emergence of multiple studies relating to one phenomenon would ideally have resulted in a convergence of findings across the piece, making the evidence base more robust, as argued by McCormack et al. (2010b, p621). However, scholars of person-centredness have produced a complex series of divergent findings among different disciplines with little correlation to, or comparison with, one another, leading to fragmentation of knowledge (ibid). As mentioned in the previous section, there was a lack of consensus on the definition of the concept, compromising its usefulness for practitioners (Edvardsson et al., 2010; Wilberforce et al., 2017). It tended to mean different things in different contexts to different people (Brooker, 2004). This fracturing of knowledge was indicated by the findings of a literature review which intended to describe the status of research on person-centred care for older adults, including existing definitions and prominent elements (Kogan et al., 2016). This study identified 15 distinct definitions of person-centredness addressing 17 central principles or values (ibid). The most common principles were holistic or whole-person care, respect and value, choice, dignity, self-determination, and purposeful living or encouragement of continued social roles (ibid).

Part of this fragmentation was because research and development into person-centredness took place in 'silos' – that is, not shared across disciplines, systems, or organisations (McCormack et al., 2010b). These research practices inadvertently created multiple and sometimes conflicting interpretations of person-centred care (ibid). Part of the research process involved operationalising a topic. When social researchers operationalise a

phenomenon, they perform a preliminary, sometimes tacit interpretation of a general or abstract idea and make it usable in practical research contexts (Olsen, 2012). Decisions made about operationalisation held ramifications for research design, and the subsequent observation, measurement, and discussion of concepts (Babbie, 2016, p46). Operationalisation, indicated by the framing of research questions, the choice of variables, or informants, would influence the available scope of findings. Some research teams employed sophisticated techniques to study person-centred care through its apparent effectiveness (Deudon et al., 2009; Kim & Park, 2017). These experimental designs involved health and care professionals performing person-centred care interventions in naturalistic settings, with researchers observing changes within clients to measure efficacy. Here, the phenomenon of person-centred care was operationalised through these changes, perceived as possible benefits to clients. In one example, a structured intervention, dementia care mapping, was measured against performance in reducing agitation and other psychiatric symptoms among people with dementia in nursing homes (Chenoweth et al., 2009). This Australian study found person-centred care effective in reducing agitation (ibid). In contrast, two, separate controlled trials of dementia care mapping in care homes identified no significant effects in reducing agitation among the residents: one in Netherlands (van de Ven et al., 2013), and another in UK (Surr et al., 2020). The UK study concluded that standard care homes may have been insufficiently resourced to deliver this model (ibid). In contrast to the study by Sixsmith et al. (1993), which focused on functioning of people requiring support, literature by Chenoweth et al. (2009), van de Ven et al. (2013) and Surr et al. (2020) examined possible changes to the behaviour of people with dementia, and whether symptoms such as agitation were reduced. The subtle differences of these operationalisations had implications for an overall interpretation of person-centred care. The narrow design of the randomised controlled trials and choice of key variables suggested person-centred care in residential settings was intended to address behavioural deficiencies within clients. This operationalisation contrasted with approaches by Kitwood, Sixsmith, and colleagues, in the 1990s. These authors set out to

explore whether person-centred care could improve self-esteem, social interaction, and physical and cognitive functioning – outcomes aligned with the original theory of personhood and therapeutic model proposed by Kitwood.

Other authors explored the concept of person-centred care from alternative perspectives. Qualitative studies adopted less rigid designs, exploring the phenomenon with a wider lens. Here, the scope of studies was broader, concerned with questions such as the meaning of person-centred care. Methods involved analysis of primary data, such as the views of key actors in naturalistic contexts, or secondary data involving analysis of existing literature. In an example of the latter, a meta-synthesis of qualitative research on person-centred care by McCormack et al. (2010b) identified four studies for in-depth analysis. The aims were to increase understanding of person-centred practice across different specialities, and to identify a future development and research agenda (*ibid*). Interestingly, three of the four studies did not include the words ‘person-centred’ or ‘person-centredness’ in their titles. These three studies covered, respectively, perceptions of energy by people with disabilities (Lerdal, 2005); experiences of mania and suffering in mental health services (Karlsson, 2004); and wandering in older people with dementia (Dewing, 2007). The authors of the study justified their inclusion because the methodological and philosophical values of the research papers were consistent with philosophical principles of person-centred care (McCormack et al., 2010b). Such fluidity of terminology was another illustration of the mutability of person-centred care, and its intersection with diverse topics in health and social care.

This body of literature contained conflicting findings. For example, one empirical study organised focus groups of nursing home workers and residents to ascertain views on the meaning of individualised care (Levy-Storms et al., 2011). Findings suggested a nuanced set of experiences and viewpoints. Residents and workers agreed that individualised care involved staff and clients getting to know one another and maintaining a relationship, but opinions were divided on the level of intimacy or attachment within those relationships (*ibid*).

Some of the worker participants believed intimate relationships were linked to person-centred care, while others felt they could only offer high standards of personalised care by maintaining emotional distance (ibid, p282). This diversity of opinion differed from strong assertions elsewhere in literature, that close interpersonal relationships were the bedrock of person-centred care (Fazio et al., 2018; Ryan et al., 2008). Similarly, McCormack (2003) suggested relational aspects of care were necessary to respect the personhood of others. These interpretations perhaps derived from Kitwood's original definition of personhood (see Section 2.3), which explicitly referenced the importance of 'relationship and social being' (Kitwood, 1997, p8).

Elsewhere, government and academics produced a substantial amount of empirical literature on personalised care, focusing on local authority social services in the UK. A government-sponsored evaluation of individual budget pilots proved a landmark study (Glendinning et al., 2008). It involved 13 councils in England and 1,000 adults using services, with a partnership between university academics and local authority staff in the pilot sites (ibid). A voluminous body of books and articles followed, evaluating and debating implementations of person-centred care by local authority social services. These included studies of the effectiveness and suitability of personal budgets, direct payments, and other state-funded forms of personalised support from the perspective of people using services (Beresford, 2012; Beresford et al., 2011; Lloyd, 2010; Mansell & Beadle-Brown, 2004; Moran et al., 2013; Rodrigues, 2020; Slasberg et al., 2012; Woolham et al., 2017). Other commentators examined the administration of personalised care from a social policy perspective at local government level (Duffy, 2010b; Duffy et al., 2010) and national government level (Ferguson, 2007; Needham, 2011a, 2011b). Personalised care was explored from the perspective of local authority-employed staff in day centres (Needham, 2013), social work departments (Duffy, 2010a), and service commissioners (Davies et al., 2021). A Department of Health-sponsored pilot project evaluated the extension of direct payments to residential care (Ettelt et al., 2018), an indication of the government's

willingness to extend person-centred approaches into every part of the care sector. During a review of literature pertaining to person-centred care and its implementation in England, there appeared to be more studies involving staff with protected titles, such as social workers, and fewer studies involving privately employed or self-employed care workers. These examples indicate a strong emphasis on state-funded services and policies in recent literature on person-centred approaches in the UK. A small body of literature concerning the care practices of this under-represented section of the workforce has begun to develop in the past few years (Cooper et al., 2018; Norrie et al., 2021; Woolham et al., 2019), although not all specifically explored person-centredness.

These contested interpretations and operationalisations underlined the breadth of competing findings and interpretations in literature on person-centred care. This section has substantiated the finding that siloed attempts at research and development in this area have created divergence, rather than convergence, of knowledge (McCormack et al., 2010b).

2.6 Practice models to aid implementation of person-centred care

In addition to the diverse body of literature testing the conceptual parameters of person-centred care, authors have constructed good-practice manuals aimed at front-line professionals. These practice frameworks, sometimes published in book format, have been designed to break down the complexities of person-centred care into achievable steps (Brooker & Latham, 2015). They will be discussed in this section, as they may elucidate understanding how professionals were being encouraged to translate and apply seemingly abstract goals of person-centred care into practice.

One of the key practice manuals was the VIPS model (Brooker, 2004), aimed at offering clarity to care professionals, managers, and people using services on the use of person-centred care in dementia services. VIPS stood for valuing people with dementia ('V'), treating them as individuals ('I'), viewing the world from their perspective ('P'), and a positive social environment ('S' - *ibid*). A supplementary textbook formed the basis of a training programme for dementia care providers, delivered by the authors (Brooker & Latham, 2015). The book described 25 indicators to help nurture the personhood of those receiving and delivering care (*ibid*). Indicators covered themes such as inclusion, enabling, relationships, training, individual support and care, and communication (*ibid*, pp177-178), implying a broad infrastructure was required to deliver the model. The objectives were that the person with dementia would enjoy independence, autonomy, joy, life satisfaction, fulfilment, and a sense of well-being (*ibid*, p25). Workers were encouraged to focus on the strengths of a client and ways of increasing their social confidence (*ibid*, pp13-14). The authors said Kitwood's works, which highlighted the impact of social environments on people with dementia, had provided the theoretical basis for the framework (*ibid*, pp17-18).

Another significant model developed by academics was the Person-Centred Nursing Framework, derived from empirical research on older people's care (McCormack & McCance, 2010), introduced in Chapter 1. The framework required staff to have appropriate skill-sets, which should be complemented by shared decision-making and supportive working environments (McCormack & McCance, 2006). In order to fully realise person-centred care the whole culture of a workplace may have to be changed, in order to foster positive relationships between care staff, clients, their families and communities (McCormack et al., 2010a). Like the model outlined by Brooker and Latham (2015), the complexity of the Person-Centred Nursing Framework required systemic approaches to planning and delivery at individual, organisational, and strategic levels (McCormack & McCance, 2006, p478). The anticipated rewards were increases in the well-being and autonomy of older people using services, while

professionals would have opportunities to develop creative practice (McCormack & McCance, 2010, p17). The onus fell on two key groups to implement the model effectively: managers, who must use their skills to foster a supportive working environment, and front-line workers, who should commit to understanding their own values base through self-reflection and develop individual approaches to person-centredness (ibid). This depiction was shared by another study, based on a literature review of the fundamental characteristics of person-centred care involving people with dementia (Fazio et al., 2018). The authors recommended workers should gain information about the person's values, beliefs and interests, and such knowledge should 'inform every interaction and experience' (ibid, p18).

The combined effect of these practice models and wealth of policies framed around the individual created a sense of ubiquity surrounding the concept in long-term care. One group of authors remarked there was 'no serious alternative' to the tailoring of services around individual people's needs and circumstances (Mansell & Beadle-Brown, 2004, p3). However, this seemingly infallible orthodoxy was challenged by others, who criticised a perceived over-emphasis on consumerism in conceptualisations of personhood. The Senses Framework (Nolan et al., 2004) attempted to re-frame the approach to personhood by nurturing the social relationships and community networks which contributed to older people's lives, instead of a narrow, individual focus on independence and autonomy. This model placed equal importance on people using services, relatives, unpaid carers, and professionals (Ryan et al., 2008, p79). The authors believed interdependence, rather than individualism, was central to a vision of personhood (ibid, p76). When implemented effectively, relationship-focused care should have created a sense of security, belonging, continuity, purpose, achievement, and significance, among everyone involved in the caring process (Nolan et al., 2004, p49). These were the six 'senses' (Ryan et al., 2008, p79). The objective of achievement, for example, could relate to making progress towards specific goals for the person needing support, staff member, or family carer. The life goals could relate to making valued

contributions for an older person, or 'to know you've done your best' on the part of a family carer (ibid, p81). Ultimately, the goals' contents were open-ended and dictated by the person themselves, in a manner espoused by Rogers (see Section 2.2).

The emphasis on interdependence and belonging in the Senses Framework (Nolan et al., 2004) resembled critiques of caring developed by feminist theorists in recent decades. For example, Tronto (1998, p17) argued that caring was a profoundly moral activity, engendering responsiveness and intimacy between care-giver and receiver. The 'ethic of care' theory assumed caring was part of a full life process, in an acknowledgement of the natural vulnerability of humans (ibid, p19). In many societies around the world, the moral activity of caring was frequently delegated to family members. The welfare systems of some countries, such as Japan, were supportive of familialist traditions (Ochiai et al., 2012). In these structures, adult children tended to remain in parental households and took responsibility for caring for elderly parents (ibid). The work by Nolan et al. (2004) appeared to reflect some of these alternative, family- and community-centred schools of thought, often overshadowed by arguments in favour of individualism in debates on person-centredness.

The existence of these frameworks pointed to a sense of complexity about the concept of person-centred care, as it applied to front-line care settings. Perhaps the authors felt there was a need to address an accumulative dissonance surrounding its meaning. Meanwhile some critics, such as Nolan et al. (ibid, p46) had begun to question whether the idea in its current policy manifestation was a 'panacea', proposing alternative methods to stimulate personhood and improve older people's care.

2.7 Critical overview of literature

The criticisms by Nolan et al. (ibid) in their justification of the Senses Framework were an example of some of the contentious debates regarding the development of person-centred care in policy and practice. Section 2.4 touched on some of the criticisms raised by commentators, concerning the skewed nature of interpretations of the benefits of person-centred care, and the mutability of its meaning. To begin rounding off the chapter, I shall add my own observations to these points, based on analysis of the body of literature discussed here.

One of the most valid criticisms, in my view, was that proponents of person-centred care overlooked weaknesses in the evidence base to identify the effects of the approach on people using services. As shown in Section 2.2, Kitwood relied on case studies and vignettes to illustrate the practical applications and benefits of individualised approaches. This approach lacked validity, in methodological terms, because some of the hallmarks of high-quality, qualitative research involved presenting the rationale for sampling and methods for gaining access to participants, to aid transparency (Seale et al., 2004). These features appeared to be missing in Kitwood's works. Some of the subsequent advocates of individualised approaches, post-Kitwood, tended to overlook empirical literature which challenged their positive view, resulting in skewed perspectives (Ferguson, 2012). For example, the article by Sixsmith et al. (1993, p993), introduced in Section 2.2, openly stated the evidence from their study was 'used to argue for a more positive approach to dementia care', implying a sense of bias. The authors concluded that the data supported a hypothesis in favour of 'dementia' and the person-centred care initiative (ibid). However, Sixsmith et al. did not, in my view, adequately explain the existence of outcomes linked to residents in two of the three homes in the study, showing patterns of dysfunction and deterioration (ibid). Section 2.5 introduced the evaluation of individual budget pilots by Glendinning et al. (2008). This study identified a positive impact on quality of life for people with mental health problems, but a negative impact for older people's quality of life (ibid). This suggestion of a negative effect on well-being on a key client group was seldom

addressed by advocates for personalised approaches. The inclusion of a case study cited by a member of Parliament in a paper on personalised care (Duffy, 2011), representing a glowing endorsement of person-centred care, was striking. The politician in question, Nick Clegg, went on to become a senior minister in a government which heavily promoted person-centred policies. Duffy (ibid) did not include any caveats about the possibility of political bias or vested interests swaying his viewpoint. This absence was another flaw in efforts to substantiate the values of person-centredness, indicating a trend towards scholars becoming advocates to a cause while relying on anecdotal evidence from potentially biased actors within the policy-making system. The complexities of person-centred care were glossed over; policy and research on the concept represented a triumph of hope over experience (O'Rourke, 2014).

These weaknesses formed part of a series of inconsistencies identified in literature exploring the characteristics of person-centred care, discussed earlier in this chapter. As Edvardsson et al. (2010) pointed out, sometimes empirical foundations of some practice models in the literature were unclear. The authors argued evaluation studies of person-centred programmes did not always explain what constituted person-centred care in the intervention under scrutiny (ibid). The literature review by Kogan et al. (2016, p5) introduced in Section 2.5, suggested themes such as 'holistic, whole-person care', dignity, and individualised care were integral to person-centred care. Critics might have viewed these terms as tautological, with one subjective, values-related term being used to describe another. This rhetorical sleight-of-hand appeared to form part of a trend of circular arguments featuring in discussions about the nature of person-centredness. To paraphrase an observation by Spicker (2013) about specious policy arguments, discussed in Section 2.4, person-centred care would, by definition, be 'whole-person care' as it would need to relate to the whole of the person to be fully person-centred. Attempts to define person-centred care by Kogan et al. (2016) did not, in my view, advance understanding of the parameters of the concept. In the other, related, inconsistency, some of the formal evaluations of person-centred interventions contained assumptions

about the nature of the concept which appeared problematic. For example, the randomised controlled trial by Surr et al. (2020) selected agitation as its primary outcome measure. This operationalisation implied person-centred approaches were a means of managing deficits or repairing damage within a person's behaviour. Yet this assumption was at odds with the original aims of Rogers' client-centred therapy, as outlined in Section 2.2, which sought to nurture a person's strengths and self-belief. It also conflicted with Kitwood's theory of personhood, whose aim was to cultivate the retention of capacities by enhancing remaining strengths rather than managing deficits (Stein-Parbury et al., 2012). As mentioned in Section 2.5, the way person-centred care was operationalised in literature had contributed to a sense of distortion and detachment of the concept's meaning from its therapeutic origins (Ferguson, 2012).

In addition to these weaknesses, it appeared some practice recommendations were based on an idealistic interpretation of the care sector. Some of the suggestions were logical when one considered them hypothetically, but it was difficult to envisage how they would work in a pressurised environment. For example, as discussed in Section 2.6, Fazio et al. (2018) suggested care professionals should gather knowledge of the person's values, beliefs and interests, and such knowledge should 'inform every interaction and experience'. Studies such as these seemed to be intended to provide a bridge between theory and practice. However, the complexities of this immense task of informing every interaction and experience with clients went unaddressed; no detailed, practical suggestions were included to elaborate on the recommendation by the authors (*ibid*). To pay credit where it is due, the models authored by Brooker and Latham (2015) and McCormack and McCance (2006) were detailed and recognised the complexities of the subject. However, they stated a broad group of prerequisites should be in place to support workers and managers attempting to translate person-centred principles into practice. In light of difficulties experienced by the care workforce in England (see Chapter 1), such as time pressures, high turnover, and inconsistent training experiences, it

seemed recommendations outlined in some of these manuals would be difficult for many care workers to achieve. A recurring argument by some scholars was that person-centred practice was effective in the context of the right conditions (O'Rourke, 2014), yet the fact that the right conditions were rarely achieved was sometimes glossed over by proponents of person-centredness (ibid).

While there were apparent deficits in some areas of literature, other angles appeared to have reached saturation. Building on the discussion in Section 2.5, it appears state-funded social services, exemplified by direct payments and personal budgets, have dominated debate on policy interpretations of person-centred care. As a result, personal budgets and direct payments could have come to be perceived as the only way of allowing older people to express preferences through person-centred care (Manthorpe & Samsi, 2016). The high concentration of literature involving this topic tended to overlook the fact reported in Chapter 1, that 79% of adult care jobs in England were found within independent-sector employers, and only 7% of jobs within local government (Skills for Care, 2021d). Other scholars were starting to look at ways in which person-centredness was experienced by people outside the apparatus of local government – for example, focusing on the experiences of people paying for care services privately (Henwood et al., 2019; Tanner et al., 2017). However, an overriding bias towards institutional frameworks, staff with protected titles, and state-funded care as foci of recent literature was a finding in itself. This trend added to a sense of marginalisation surrounding the 'rank and file' care workforce, who frequently received the least attention in debates on standards in health and social care (Cavendish, 2013).

2.8 Aims and objectives of research

The thesis so far has described how policy-makers have been promoting a vision of person-centred values across the adult care sector in England. The government and sector bodies have been seeking cooperation from care staff, described within statutory guidance as playing a central role in delivering high-

quality services, (Department of Health and Social Care, 2020, paragraph 4.28). Care workers in particular were important actors in this policy implementation process. This was because care workers applying person-centred practice could have a direct impact on the well-being of people using services (Stein-Parbury et al., 2012).

Many welcomed the shift towards person-centred care as matching core principles of social justice. However, these policies have not been without controversy, with concerns centring on two key issues. Firstly, the sense of ambiguity surrounding the meaning of the topic as it pertained to front-line practice. The contentious debates regarding the interpolation of person-centred approaches into adult care guidance were outlined in Section 2.4. The tendency among commentators to ignore grey areas had a detrimental effect on a general understanding of the concept: as debates swung from one polarised viewpoint to another, nuance was overlooked. Some commentators adopted a politicised, evangelical tone and the meaning of the concept appeared to have become detached from its therapeutic origins. The practice models detailed in Section 2.6 attempted to address this problem by clarifying the theoretical characteristics of person-centred care, and the outcomes associated with it. The models presented by McCormack and McCance (2006) and Brooker and Latham (2015) both suggested individualism and autonomy were core themes and outcomes. This emphasis was consistent with principles of key legislation (Human Rights Act 1998; Care Act 2014), and national care guidance promoting independence among clients, described in Chapter 1. However, these explications could also have been problematic. The recurring endorsement of independence as a chief outcome of person-centredness had the effect of implicitly rejecting alternative interpretations of personhood. For example, the ethic of caring, which acknowledged people's inherent vulnerability, or familialism, outlined in Section 2.6. It was possible that alternative understandings of person-centred care, not necessarily captured in the literature discussed in this chapter, would be cropping up in different parts of the care sector.

Secondly, the government required the support of a workforce of huge size and diversity, comprising more than one million people, to achieve its aims. As discussed in Section 1.8 of Chapter 1, employers were responsible for ensuring employees received sufficient training and development in person-centred approaches. However, many employers were based in private companies, which may have run their businesses according to commercial reasons, inconsistent with government policy objectives (National Audit Office 2018). Yet making sense of person-centred principles required detailed planning and reflection on one's own behaviour, according to scholars. McCormack and McCance (2006) argued staff needed to understand their own values base and develop their own approaches to person-centredness. Recently, academic literature has begun to acknowledge the relevance of care workers' individual values, experiences, and life skills as valuable aspects of workforce development for both workers and employers (Williams et al., 2016). Yet, as noted in the introduction to Chapter 1, evidence of the local reasoning of front-line professionals as they attempted to make sense of person-centred policies was less established. This lack of knowledge particularly applied to the practices of personal assistants or self-employed care workers, who may have offered distinctive interpretations of person-centred care. Even the numbers of such staff were unknown: an official estimate of 100,000 personal assistants working in England did not offer a full picture as it excluded staff working privately for clients (see Section 1.6 of Chapter 1).

In the context of these challenges and information deficits, an actor-centred perspective of social policy could lead to a better understanding of how person-centred care is translated into practice on the front line. According to this perspective, the understandings and sense-making of front-line professionals are crucial to policy implementation (Dean, 2019, p66). Interpretivist philosophies suggested social reality had an intersubjective character (Yanow & Schwartz-Shea, 2013). This perspective may have been particularly relevant to settings such as social care, where professionals likely shared habits of

thinking, ways of seeing, and shared meanings across communities of practice (ibid). An actor-centred study of meanings could lead to more nuanced understanding of how workers and managers made sense of a convoluted policy terrain involving interpretation of complex, abstract values through their own sense-making (Morgan, 2019). The tacit, taken-for-granted assumptions of these professionals form the empirical fabric of this thesis.

This thesis aims to address these contradictions by examining how policy was understood and articulated in front-line practice. The aim of the project is to explore meanings and interpretations of person-centredness from the perspectives of care workers and managers specialising in supporting older people.

The research questions are:

1. *How is person-centred care conceptualised in theory and policy?*
2. *How do care workers and managers understand and interpret the concept in the context of front-line practice?*
3. *Which beliefs, values, and practices underpin the practice of person-centred care among these care workers and managers?*

The research objective is to examine relationships between theory, policy, and practice in this area.

The next two chapters will discuss the way these topics will be addressed through the design of an original research project, beginning with a discussion of methodology in Chapter 3.

Chapter 3: **Methodology**

3.1 Introduction

The previous chapter stated the aim and objective of the research project: to explore meanings and interpretations of person-centred care from the perspectives of care workers and managers, and explore relationships between theory, policy and practice in this field of long-term care. The first two chapters offered critical overview of theory and policy developments in relation to person-centred care, answering the first research question: how is person-centred care conceptualised in theory and policy? The empirical elements of the study will provide answers to the second and third research questions: how care workers and managers understand and interpret the concept, and which beliefs, values and practices underpin person-centred practice among these actors. Designing the empirical elements of the study involved a series of methodological decisions to ensure the robustness of research methods and outputs. This chapter outlines core philosophies and assumptions informing these design issues. It explains the relevance of interpretivism, phenomenology, and interpretive policy analysis to my thinking, the choice of main informants, and research methods for the project, with reference to key authors and concepts.

It begins with a discussion of philosophies of social science, and the emergence of interpretivism in the canon of methodological literature.

3.2 Philosophies of social science and the interpretive turn

Social research aims to increase our knowledge and understanding of the world around us. To increase scientific validity and offer theories up to debate and

adaptation, researchers adopt methodology. This term refers to any set of assumptions, principles and traditions guiding empirical inquiry, while substantiating arguments about the social world (Given, 2008). Methodologies are informed by beliefs about the world regarding ontology, the nature of reality, and epistemology, the development of knowledge. Scholars have debated these complex metaphysical issues over several centuries; constructing theories which, taken together, have formed paradigms of social science. Such philosophies are important aspects of debates about the world around us, as they inform research designs and what constitutes valid evidence about phenomena of interest (Pope & Mays, 2020).

One of the most influential paradigms in scientific research is positivism. The idea of a single, reliable description of phenomena, based on observation and measurement, is a central positivist belief. It is based on the principle that the world existed as a knowable entity, independent of people's perceptions (Miller & Brewer, 2003, p237). This belief is part of a theory, known as foundationalism, which argues there is an inherent trustworthiness in knowledge relying on foundations, requiring no further justification or interpretation (Schwandt, 2007, p120). For example, a foundationalist argument may have gained credibility by being supported by a theory of mathematics authored by Descartes or Plato – an example of a lawlike truth or generalisation which some philosophers believe govern the universe (Pernecky, 2016). This is an example of an absolutist belief: one that represents an absolute truth, holding in all situations. Absolutist methodologies are applied in natural sciences and postulate claims to facts about the world (Morrow & Brown, 1994). These assumptions hold implications for the way phenomena are studied in research. For example, scientists attribute universal properties to natural phenomena which are captured by quantifiable or numerical variables. Measurement tools were developed to describe different variables, allowing researchers to measure, say, climate, in terms of a specific variable such as average rainfall. Scientists applied the same measurement techniques to offer generalised pictures of different regions, lending further validity to knowledge (Richardson,

1990). This exploration of the natural world, supported by standardised methodological tools, exemplifies a positivist scientific philosophy. Traditions of applying numerical measurement to specific aspects of phenomena form the basis for quantitative research (Miller & Brewer, 2003).

In addition to widespread use in natural sciences, these foundationalist principles were widely applied to social sciences in the 19th and 20th centuries. The adoption of quantitative methodologies was due to the appeal of statistical generalisation, which claimed to show qualities of a phenomenon existing across most examples of it (Schneider, 2007). Sociological debate led to the emergence of structuralist visions of society, which argued behaviour was influenced by social structures and institutions (Baert & da Silva, 2010). Within this paradigm, human agency is minimised: society is perceived as being influenced by broader social forces transcending individuals (ibid). This philosophy was distinguished by systematic methodologies involving complex mathematical formulae, which scholars have praised for their contribution to sociological debate. Such philosophies lent credibility to social research through efforts to become more transparent and free from ideological bias (Brinkmann & Kvale, 2018, p23). Indeed, techniques involving statistical measurement and generalisation remain influential within social policy discourse in the 21st century, particularly in health and social care. The National Institute for Health and Care Excellence (NICE), for example, developed best-practice guidelines for health and social care professionals by evaluating the latest research findings. One report looking at falls among older people reviewed the effectiveness of exercise programmes (National Institute for Health and Care Excellence, 2019), comparing quantitative evidence (ibid). NICE concluded exercise programmes for older people were largely effective, and recommended their use for older people in some settings at risk of falling (ibid, p9). This form of policy-making illustrated the value placed on quantitative evidence and statistical trends.

In the social sciences, alternative paradigms of society existed, casting researchers and objects of study in a different light. Theories which rejected foundationalist philosophy and the notion of absolute truths became associated with relativist thinking. In contrast to absolutism, these theories assumed claims to knowledge could only be understood relative to something else, such as social or cultural practices (Given, 2008). Researchers may have shared an empirical interest in the generation of knowledge through observation, whether they associated themselves with foundationalism or relativism. However, the latter paradigm was based on alternate ontology in which objects of inquiry were viewed as possessing dynamic qualities of volition and agency (ibid). This assumption contrasted with views about objects of study in natural science, which were said to have different qualities (ibid). These alternative epistemologies challenged the perception that universal truths could be substantiated by evidence. Criticism was partly linked to arguments about the researcher's position in society and the difficulty of acting as an impartial observer. The researcher occupied an integral position in the arena they wished to explore, unable to stand apart to take an objective view, or avoid influencing the phenomenon they wished to study (Giacomini, 2010). The notion of interpretation was seen as crucial to understanding the social world.

These beliefs about the status of researchers held implications for the validity of knowledge generated by research. In what became known as the 'interpretive turn', interpretations of social actors and the meanings they attached to their experiences accrued more prominence (Gilson et al., 2011). Instead of searching for causal explanations to phenomena, social scientists aimed to understand the meaning of social life and people's behaviour from an emic perspective, by exploring the actors' own interpretations of events and practices (Schwandt, 2011). For interpretivist analysts, the most pertinent meanings were made by actors with experience of situations relating to certain phenomena (Yanow & Schwartz-Shea, 2013, p19). By drawing on shared experiences and understandings, social scientists scrutinised people's common-sense, taken-for-granted thoughts and behaviours – 'local rules' of action and interaction (ibid,

p20). Themes and meanings relating to experiences from actors' own perspectives could be tested through interviews, observation, and other methods (Brinkmann & Kvale, 2018). Attitudes towards the subjective nature of the social world underpinned construction of theory, extrapolated from actors' interpretations and experiences. For example, a study of the behaviour of flight attendants and bill collectors proposed the idea of 'emotional labour', to convey people's methods of suppressing or accentuating different emotions in work contexts (Hochschild, 2012).

This spectrum of philosophical paradigms - positivism at one end, and interpretivism at another – bore implications for studies in health and social care. Research designs would depend on the ontological and epistemological perspectives of analysts. The place of interpretivism in this area of social sciences is discussed below.

3.3 Interpretivism and its place in health and social care research

Beliefs about the scientific validity of claims to knowledge depended on one's position in relation to epistemology and ontology. I noted some features of quantitative research were influenced by positivist perspectives. For example, the sample size of a study could be vast in scope: entire populations could be studied. This approach is known as probability sampling, where every member of an overall population has a chance of being included in a sample (Given, 2008). Quantitative designs are used to generalise as much as possible about a specific phenomenon. By contrast, researchers adopting qualitative traditions are interested in intensive study of features of one or a small number of phenomena (Miller & Brewer, 2003). This is because they focus on different types of questions: instead of 'how much' or 'how often', qualitative researchers use different methods to answer questions such as what is happening in relation to a phenomenon, or the meaning of a phenomenon (Merriam & Tisdell,

2015). As such, probability sampling is not necessary nor justifiable in qualitative research (ibid). Instead, non-probability sampling methods are used, where the aim is to achieve in-depth understanding of specific, information-rich cases (ibid). Meanings of phenomena are one of the core interests of researchers influenced by interpretivist paradigms, which shape the values of qualitative study. Meaning could be conveyed through people's knowledge, language, narratives, interpretations and experiences, which are viewed as important ontological properties of social reality (Mason, 2018, p110). Interpretivist studies aimed to examine people's behaviour in everyday or natural settings (Gilson et al., 2011). The emphasis on natural settings is based on the idea that phenomena and actors in the social world should not be separated from their normal context prior to empirical inquiry. People act on the basis of their perceptions of situations, rather than beliefs about objective reality (Bourgeault et al., 2010). Instead of drawing broad conclusions from statistical generalisations of wider study populations, the goal of qualitative research is to produce nuanced accounts of experience from a limited sample of objects of study (Gilson et al., 2011).

The ways in which health and social care topics are operationalised in social sciences research vary widely. I discussed examples of quantitative studies evaluating the efficacy of person-centred interventions in adult social care in Chapter 2. Several studies employed experimental designs such as randomised controlled trials (Chenoweth et al., 2009; Surr et al., 2020), which are based on positivist beliefs. Here, scholars applied standardised instruments to measure the outcomes of people involved in studies, such as the General Health Questionnaire (Netten et al., 2012b), and Adult Social Care Outcomes Toolkit (Woolham et al., 2017). The use of the Adult Social Care Outcomes Toolkit in the latter case allowed for descriptions of the effectiveness of different interventions in numerical terms. In this case, direct payments were compared with personal budgets managed by a third party by using a standardised, quantifiable, outcome: quality of life ratings (ibid). The study concluded direct payments did not secure substantive life improvements for older people

compared to managed budgets (ibid). This application of standardised instruments with fixed parameters enabled researchers to draw conclusions of generalised assessments of effectiveness, which would apparently relate to the wider sector or population. As noted in Section 3.2, researchers adopting absolutist perspectives use quantitative evidence to identify statistical trends and postulate facts about the world. Features such as randomisation, a hallmark of randomised controlled trials, are intended to ensure participants in control and intervention groups are as similar as possible across groups (Guest & Namey, 2015). This feature of the randomised controlled trial by Surr et al. (2020) enhanced the generalisability of findings in the UK, according to the authors. Positivist evaluation styles such as this are favoured by policy-makers looking for definitive answers to research questions, and have been adopted by the regulator for social care in England. The Care Quality Commission developed a standardised instrument to guide inspections of adult care services, within its remit to uphold the quality of care. This methodology assessed providers on five key indicators, including whether performance was 'caring' and 'responsive to people's needs', and offered one of four overall ratings: 'inadequate', 'requires improvement', 'good' or 'outstanding' (Care Quality Commission, 2015b). The framework was revised in partnership with government in the 2010s, as part of efforts to seek a 'single version of the truth' regarding the performance of health and social care services (Department of Health, 2014a, p6).

Qualitative methodologies adopt more flexible approaches to health and care policy research, offering fresh perspectives on phenomena. Their contribution has been valuable in eliciting perceptions of health and illness from the viewpoints of service users, the patients and clients (Bourgeault et al., 2010). Scholars have used such approaches to study person-centredness in social care while drawing on individual actors' experiences in natural settings, eliciting perspectives imbued in unique contexts and settings. For instance, knowledge was drawn from observation of caring relationships in a naturalistic study of selfhood relating to older people (Kontos, 2012). The author used ethnographic

methods in a care home to 'follow the natural stream of everyday life', observing interactions between actors (ibid, p333). The study concluded, where people with cognitive impairment were concerned, meaning was conveyed through bodily manifestations of selfhood; it recommended more attention should be paid to non-verbal communication by care workers (ibid, p340-341). As introduced in Section 2.5, a qualitative meta-synthesis of existing literature on person-centred care attempted to deepen understanding of the concept by closely analysing selected texts (McCormack et al., 2010b). The study was necessary, according to the authors, because research and development into person-centredness lacked common and shared meaning (ibid, p621). Both papers – Kontos (2012) and McCormack et al. (2010b) - aimed to capture depth and contingency of experience relating to person-centred care, while avoiding absolutist claims to truth. Their methodologies were inspired by interpretivism and focused on a small number of relevant objects of study: a single care home (Kontos, 2012) and a sample of four texts (McCormack et al., 2010b). McCormack et al (ibid, p624) explained they studied the findings chapters of included texts several times, adopting a 'naïve reading' approach, as part of an open-minded attempt to ascertain a sense of meaning. Kontos (2012, p333) explained their intention was to produce a naturalistic study, situated in the context of occurrence, to observe the complexity of a specific culture, focusing on interaction. Instruments designed to measure outcomes in a uniform manner were absent in these methodologies. The studies were perhaps deliberately designed to counter an alleged pitfall of standardised instruments, which sometimes fail to capture the fullness of experience (Polkinghorne, 2005).

Interpretivist paradigms are suited to health and social care topics for a simple reason, that interpretive acts are at the heart of care work. It relies on fine judgement and skills of attentiveness and interaction, as professionals make constant inferences based on knowledge and perceptions of clients and the care work role (Brodkin, 2007). Gaining access to local, professional knowledge concerning person-centred care would be crucial to the research design for this project. One of the ways of ascertaining this knowledge is discussed below.

3.4 Interpretive policy analysis

As noted in Section 3.3, interpretivist perspectives favour empirical designs which privilege the values and knowledge of individual actors. One social policy tradition generating theories on this type of data is interpretive policy analysis. Here, I outline the features of interpretive policy analysis and its relevance to the research question.

Some forms of policy research assume the state and other institutions are focal points for empirical inquiry. In such state-centred views, policy-making is studied from a top-down perspective, by scrutinising relationships between decision-making power and competing social and economic interests. The formation of government agendas has been explored from the perspective of hierarchical policy-making structures and interest groups (Kingdon, 2014). Implementation is viewed as an administrative task: institutions and managers recruit front-line staff and, with the backing of financial and human resources, policies are enacted (Dunn, 2016). Critics argue state-centred research is too mechanistic and focused too heavily on institutions (Wagenaar, 2011, p20). It overlooks the perspectives of policy subjects, such as end users or professionals delivering policy, which could lead to unintended consequences (ibid). In this alternative paradigm, interpretive policy analysts view policy-making and development from the bottom up. Scholars suggest public policy is indeterminate, contested, heterogeneous, and driven by action and actors (ibid). Instead of managerialist perspectives, researchers examine meanings of policies as interpreted on the ground by administrators, employees, citizens, and clients (Yanow, 2000). Analysts seek access to governance processes with material effects on individual lives (Carmel, 2019). Actors are viewed as active and reflective, negotiating structural and contextual factors yet retaining the agency to change these (Farr, 2019). The discretion of front-line professionals was a central component of the theory of 'street-level bureaucrats' (Lipsky,

2010), which examined how welfare administrators interacted with the public and interpreted rules binding their work. Lipsky's theory highlighted the translation of policy on the front line from the perspective of individual professionals and citizens (ibid). An assumption of this form of policy analysis that policy is 'peopled': developed by social actors in concrete contexts (Carmel, 2019). The phrase 'street-level' acknowledges policy implementation is inherently a local activity: imperfect hierarchical structures mean work on the front line of public services often occurs at a remove from direct oversight by managers or policy-makers (Brodkin, 2007).

The stock-in-trade of interpretive policy analysts are meanings and meaning-making. Meaning-making refers to the production of categories of thought and recognition in relation to specific phenomena (Carmel, 2019). Meanings in relation to policy are not typically accessed directly from participants during data collection, as they are often too abstract (Yanow, 2003). Instead, meaning can be elicited through the study of social action (Wagenaar, 2011). The idea that meanings are constitutive of human action is a core belief of this philosophy, prompting analysts to seek accounts of underlying intentions and beliefs preceding certain behaviours (Bevir, 2011). Actions and practices would indicate people's local reasoning (Bevir & Rhodes, 2016). Yanow (2000, p4) argued that such reasoning or 'local knowledge' is required to unlock people's interpretations of policy issues. Local knowledge refers to mundane, expert understanding of and practical reasoning about local conditions, derived from lived experience (ibid). Through this, readers could understand the consequences of policies for various people it may affect (ibid).

Although meanings could not always be accessed directly during data collection, they could be elicited in a variety of ways. Yanow (2000) described three steps towards accessing local knowledge. These were the identification of relevant artifacts – expressions of values, beliefs, or meanings; the identification of communities related to specific policy issues; and examination of discourse - how communities talked and acted regarding the policy issue (ibid). The

discourse could be expressed in language, written or spoken by actors; acts and interactions; and physical objects, including documents (Yanow, 2003).

The strengths and weaknesses of interpretive policy analysis are considered below, alongside discussion of its application to social policy research.

3.5 Applications of interpretive policy analysis to social welfare studies

Interpretive policy analysis holds an interest in actor-centred, local reasoning. These qualities are prioritised because policy enactment, as suggested by Wagenaar (2011), is messy and indeterminate. Policy in social services and the wider welfare sector in England is marked by its complexity (Morgan, 2019). Perhaps for this reason, interpretive policy analytical traditions are frequently used to examine these fields. Governance analysis – a hybrid form of interpretive policy analysis within political science - was used by one author to explore the way in which English care policy treated different types of caring relationships (ibid). An actor-centred approach was taken towards the examination of the design and delivery of care policies. Interviews and questionnaires were used to gather data from front-line practitioners and managers (ibid). The study concluded that the contradictions in the care policy landscape meant practitioners and clients resolved issues relating to statutory entitlements informally, among themselves (ibid). Morgan's contribution is an example of an actor-centred, interpretive policy inquiry yielding nuanced findings about the fine judgements and sense-making involved in a complex area of adult care delivery.

Analysts adopting this stance produce critique, which exposes the partiality or contingency of policies (Bevir & Rhodes, 2006). Understanding processes of meaning-making in practice communities could help illuminate issues and divergences which facilitate or impede policy implementation (Juntti & Potter,

2002). For example, Stafford et al. (2019) scrutinised the application of employment policies for people with disabilities in Australia, from the perspective of advocacy workers. Interviews with disability employment staff and advocacy workers were used to elicit meanings and experiences regarding capacity assessments (ibid). The authors concluded disability work policy failed to make allowances for people with disabilities in transition from education into work (ibid, p897). Elsewhere, the use of language is identified as a powerful factor in public policy in research adopting critical analysis of policy texts. For example, the remodelling of public service users as 'customers' has been attributed to rising expectations of the quality of services, and an undermining of this group's status as responsible citizens (Needham, 2006). Insights could be produced from actors whose voices were hitherto silent or unheard, yet played an integral role in policy implementation (Yanow, 2000). By involving care workers and managers, my study could help to address concerns these groups' views were often overlooked in debates on policy and practice (see Chapters 1 and 2). Interpretive policy analysis has been praised for making civil society more pluralist and creating a platform for marginalised people (Healey, 2011). In one example, a partnership between the Guardian newspaper and London School of Economics interviewed hundreds of people involved in riots across England in 2011 (Lewis et al., 2011). While not explicitly describing itself as interpretive policy analysis, this partnership reflected key tenets of the approach, such as an interest in decentralised accounts of meanings attached to policies. The study highlighted the impact of stop and search powers from the perspective of both citizens and police officers, which led to a national review of these powers (ibid). These examples have shown how interpretive policy analysis texts can lead to novel insights about policy while making a positive contribution to civil society.

In terms of weaknesses, some have suggested the model's eclectic approach to methods invite accusations of vagueness. Ventriss (2012) criticised Wagenaar (2011) for failing to outline a clear methodological strategy for data collection and analysis. Elsewhere, some methodological applications had been

inconsistent. One example can be seen in a study of policy on integrated care programmes in England and discourse surrounding these policies (Hughes, 2017). The author claims to have designed the inquiry around principles of interpretive policy analysis, but the findings only appear to relate to a discourse analysis of policy documents, with commentary comparing the UK government's healthcare policy with that of overseas governments (ibid). In Hughes' study (ibid), it was unclear how the policies acquired meaning through local reasoning of actors involved in developing or implementing them. As suggested by Green and Thorogood (2004), some qualitative studies claim to use highly specific analytical approaches, when in reality, the authors produce thematic content analysis. This is one of the pitfalls I have tried to avoid, by explaining the steps and decisions taken at each stage of the research process (see also Chapter 4).

An interest in gaining access to the local reasoning of actors is one method of studying meaning. Another philosophy influential in debates on qualitative inquiry is phenomenology, the underlying principles of which are discussed in the next section.

3.6 Phenomenology

The project methodology was influenced by a desire to highlight the local reasoning of participants underlying the delivery of person-centred care, and practices and discourses reflecting the concept's meaning. By foregrounding tacit assumptions and values of individuals informing their professional understanding of the topic, the study was aligned with core principles of interpretivism. A related branch of interpretivism is phenomenology.

Phenomenologists such as Heidegger believed the properties of everyday phenomena were mostly hidden and forgotten about (Frechette et al., 2020). To illustrate this claim, Heidegger would ask people to describe the walls of a local grocery shop - a task most, it was argued, would find difficult even if they had

been there several times (ibid). Layers of 'forgetfulness' were features of everyday existence: the purposes of objects tended to go unnoticed in our daily lives, only becoming apparent when something went wrong (ibid). The objective of phenomenology was to pull away layers of 'hiddenness' (ibid). Analysts could determine the essence of that experience by studying manifestations of the essence and structures that governed instances of it (van Manen, 1990). The focus is on the lived experience and social practices of participants: there is an ethos of respect for the voices and actions of those studied (Given, 2008). Phenomenology has been praised for offering a distinctive contribution to social sciences, particularly in social welfare areas such as nursing and education (McCaffrey et al., 2012). This is because of its unique capacity to offer insights into complex phenomena in their historical, political, and ethical contexts (ibid). It has been valuable in producing fresh perspectives on values-based concepts in healthcare. For example, one study offered an alternative conceptualisation of patient-led nursing via an existential view of well-being (Dahlberg et al., 2009). Elsewhere, an interview study explored nurses' understandings of honesty (Erichsen et al., 2010). The propensity for offering hitherto unseen insights into the meaning of concepts in health and social care research made phenomenology a valuable perspective to guide the design of the current study.

The philosophical principles of social science discussed in the chapter so far helped to guide design of the research project. The next sections will explain the rationale behind decisions taken in this regard.

3.7 Research design, as shaped by interpretive policy analysis and phenomenology

In the interests of transparency, I endeavoured to produce a clear account of research planning and execution. In choosing the most appropriate stance from which to answer the research questions, I reflected on the nature of person-centred care in light of interpretive policy analysis and phenomenology. The

next four sections will explain the rationale behind my research design, beginning with philosophical perspectives and paradigms.

My ontological perspective was influenced by the theory of phenomenology, introduced in Section 3.6. I considered empirical literature on person-centred care and the settings in which person-centred work takes place. Practice frameworks describe the importance of staff developing their own approaches to person-centredness, underpinned by professionals' understanding of themselves and their values (see Section 2.6 of Chapter 2). These understandings and experiences are often tacit, not usually revealed at face value during interviews or other research activities. This assumption invokes Heidegger's belief that properties of everyday phenomena are often hidden, and the essential characteristics of an object could be revealed through manifestations of those properties – part of a phenomenological perspective (Frechette et al., 2020). From this assumption, meanings attached by workers and managers to person-centred care could be viewed through manifestations of the concept, from the participants' perspectives. I considered another school of thought developed by interpretivist scholars: symbolic interactionism. This tradition views interaction as a vital process for the formation of human conduct and beliefs, rather than being merely a forum for expression (Blumer, 1986). Blumer believed people were engaged in an ongoing stream of inferences as they interpret actions (ibid). Symbolic interactionist attitudes towards empirical inquiry appeared to offer strong methodological grounding for capturing expressions of meaning from respondents, especially in professional environments. However, symbolic interactionism has not escaped criticism. One group of authors debated whether some interactionist studies of work were too focused on social action, while overlooking cognitive or interpretive aspects of work (Bloor & Wood, 2006). Care workers and managers interact with colleagues and clients on a daily basis, suggesting a study of meaning-making influenced by symbolic interactionism would be appropriate. However, I rejected this school of thought as a potential methodology for this project. This was partly due to restrictions imposed due to the COVID-19 pandemic: face-to-face

fieldwork was not possible, and it would have proved difficult to capture the interactive elements of the caring role. Therefore, for practical and theoretical reasons, phenomenology was chosen a key influence.

In addition, my view of person-centred care was shaped by an interpretivist attitude. I queried the rigid epistemological assumptions of the Care Quality Commission, whose regulatory system assumed a universal version of truth and quality were attainable in social care. Some commentators have criticised this approach for being one-dimensional, arguing there is an inherent difficulty in measuring 'good' or 'person-centred' care in an objective sense (Lewis & West, 2014). A universal or absolutist vision conflicts with interpretivism, which questions whether objective criteria could ever identify knowledge as 'true' (Blaikie & Priest, 2018). Where complex notions such as personhood and person-centred practices are concerned, meaning can be contextually specific: practices may take on different meanings in different situations (Unger, 2005). The role of qualitative research in health and social care topics is to examine detail and record characteristics of participant behaviour (Cardano, 2019). These attributes mirror the professional tasks of care staff attempting to make sense of person-centred principles, by using negotiating skills and flexibility (Hayes et al., 2019, p10). This emphasis on nuance is appropriate for person-centred care, in which knowledge of the concept has become fractured due to compartmentalisation of different research and policy communities (McCormack et al., 2010b). Although many interventions and evaluations describe delivering person-centred care in different settings, the lack of agreed service attributes makes it difficult to focus discussion on any core model (Wilberforce et al., 2017). Contrary to the impression created by regulation of there being a 'correct' method of performing person-centred care, I thought multiple interpretations and meanings of the phenomenon would have developed in different pockets of the sector.

As highlighted in Section 3.4, the core building blocks of interpretive policy analysis are meanings and meaning-making. Meaning can be identified through analysis of social action (Wagenaar, 2011). Here, the local reasoning of actors involved in policy implementation situations, embodied by actions and practices, is key: studies focusing on this local knowledge can unlock people's interpretations of policy issues on the front line of services (Yanow, 2000). Adult social care is a complex policy area in which concepts such as personhood are promoted. A lack of consensus about the meaning of personhood and person-centred care puts the onus on employers and individual professionals to interpret and enact these concepts in their day-to-day practice. In light of these grey areas of policy and practice, I felt interpretive policy analysis was a suitable framework for analysing the way in which the policy issue was framed by people with direct roles in delivering services. This is because the tradition of interpretive policy analysis rejects the notion of a single, 'correct' implementation of policy (ibid), contrary to the expectations of social welfare regulators in England. Instead, it opens up the possibility of identifying a variety of meanings linked to policy concepts, shedding further light on the phenomenon in question.

My interest in meanings and interpretations of person-centred care from the perspectives of workers and managers was underpinned by recognition of the latent nature of the meaning of abstract concepts within professional surroundings. Adopting a phenomenological outlook to the research would offer an analytical bridge towards understanding manifestations of person-centred care. One of the activities associated with a phenomenological approach is the examination of voices, actions and texts in depth, moving between parts of the phenomenon and the whole (Given, 2008). I planned to perform these tasks with qualified naivete - an approach open to discovering new and unexpected phenomena (Brinkmann & Kvale, 2018). This could include, for example, identifying knowledge of person-centred practice that differs from common conceptualisations. (See Chapter 4 for an account of the research as it was conducted.)

This section has summarised the rationale behind my research design: influenced by realist ontology and phenomenological interest in the essence of phenomena, guided by traditions of interpretive policy analysis. With these principles in mind, I selected the main actors to be recruited to the study and an appropriate sampling technique, which will be discussed next.

3.8 Research design: sampling and choice of informants

The research project was concerned with capturing participants' interpretations of person-centredness: the beliefs, values and practices underpinning implementation in front-line care practice. This section explains my choice of data collection activities in the context of the research questions.

My intention was to explore meanings of person-centred care in the context of social policy, and a key platform for policy implementation in this area was care practice. I intended to examine interpretations of person-centred care in practical settings, and the taken-for-granted features of care work through to elicit insights into the meaning of the phenomenon. Clients receiving care have been the subject of numerous studies exploring the effects of person-centred care on their lives through quantitative research methods (Chenoweth et al., 2009; van de Ven et al., 2013; Bolenius et al., 2017; Surr et al., 2020). Other research has explored the experiences of older people receiving person-centred forms of care (Donnelly & Macentee, 2016; Baxter et al., 2020). However, there has been less research about the practical knowledge and perceptions of care staff regarding policy concepts. Their judgements were integral to the delivery of person-centred approaches on the front line of care.

As noted in Section 1.9 of Chapter 1, care workers seldom featured in public policy debates at the time of writing. That chapter also described a lack of representation of this group in workforce development bodies, which were

heavily promoting person-centred care as a practice objective. Additionally, within this policy shift towards person-centred practice, more demands were being placed on front-line care workers (Cavendish, 2013). As discussed in Section 3.3, quality in care work relies on professional judgement, with practitioners making constant inferences based on knowledge of clients and the care work role (Brodkin, 2007). The literature review on which Chapter 1 was based suggested a paucity of academic research drawing on the practical knowledge and experience of care professionals. I concluded that professional judgement was integral to delivery of person-centred care and decided, therefore, that the main informants would be front-line care staff.

From an interpretive policy analytical perspective, care professionals were a 'policy-relevant group' who may have interpreted concepts in ways differing from the original intentions of policy-makers (Yanow, 2000). Researchers guided by interpretive policy analysis study acts through which policy meanings are conveyed (ibid). As such, I planned to gain access to 'local knowledge' (ibid) about person-centred care – situational and contextual knowledge, perhaps expressed through beliefs, values and practices – helping actors make sense of phenomena. Knowledge could be gained about nuances and interpretations within a contested area of practice which may have gone unnoticed. This interpretive policy analytical design was suited to the research question because policy structures for long-term care in England delegated responsibility for interpreting abstract principles, linked to person-centred practice, to front-line professionals (as explained in Chapter 1). The caring role required frequent exercise of discretion, judgement and agency (Brodkin, 2007), aligning with an interpretivist paradigm. Data pertaining to professionals' common-sense knowledge, practical reasoning, beliefs, and experiences (Bevir & Rhodes, 2016) regarding person-centred care would be highly relevant to the research questions.

A purposive sampling approach was taken to identify participants. A purposive approach means participants are selected on the likelihood of being 'information

rich', with a view to being able to offer material relevant to research questions (Flick, 2018b, p88). Care workers were chosen because their position on the front line of services meant they were often the first point of contact between clients and the care sector. Their role in providing direct care meant they would be knowledgeable about issues involved in delivering person-centred approaches in day-to-day work, given the ubiquitous nature of the concept. Managers were chosen because of their role in training and supervising care workers, which would necessarily involve understanding and directing person-centred approaches among staff. Managers were regulated by the Care Quality Commission, which included person-centred care as one of its fundamental standards (see Chapter 1). It was important that people with recent, first-hand experience of implementing long-term care policies in England could share their viewpoints to ensure the relevance of data to the research topic. Therefore, I decided to recruit care workers and managers who were employed in the care sector in England at the time of interviews. Each participant would have a minimum of one year's experience, as it was more likely they may have completed basic training by this stage. Given the broad split between residential and community care in the sector in England (see Chapter 1), participants in both settings were included. I considered self-employed staff or personal assistants an important section of the workforce, as their ideas about person-centred care may have varied in comparison to employees of provider companies. Therefore, I decided to include several self-employed workers within the cohort. Increasing the diversity of employment arrangements was intended to ensure variety in the phenomenon could be captured in the empirical material as far as possible (Flick, 2018b).

Commentators have suggested normative framings of person-centred care, with connotations of individualism, independence, and autonomy, were untenable for older people (Nolan et al., 2004). Given such questions regarding suitability, and older people's status as the largest client group in the care sector (NHS Digital, 2021), I decided the study would focus on professionals supporting adults over the age of 65.

The choice of methods for exploring meanings of person-centred care from the perspective of these participants is discussed next.

3.9 Research design: semi-structured interviews by telephone and online

My interest lay in the lived experience of care professionals, who may have been able to talk about their experiences of the phenomenon and the way it is implemented. Although proponents of interpretive policy analysis did not stipulate a singular template for research design, they tended to favour qualitative methods such as observation and interviews (Wagenaar, 2011; Yanow, 2003).

Qualitative interviews have been valued in social scientific literature for many years (Brinkmann, 2013, p21). Interviewers seek to gain access to the knowledge, experiences, and perspectives of research subjects (Bourgeault et al., 2010). Qualitative interviews have been used as a forum for in-depth exploration of meaning, and as such were considered suited to research seeking to better understand a range of phenomena, particularly within health and care research (ibid). This method would provide opportunities to elicit local knowledge and reasoning of participants (Yanow & Schwartz-Shea, 2013), allowing in-depth exploration of professional understandings of relevant concepts. As discussed in Section 3.4, interpretive policy analysts seek access to cultural practices and participants' reasoning (Yanow, 2000). Researchers can achieve these goals by exploring how a community of professionals talked and acted in relation to the policy issue (ibid), which made interviews a suitable method of data collection. During interviews I sought to obtain accounts of situation-specific usages of concepts and policies and cultural practices, as suggested by Yanow (2000). The aim was to examine typical actions and

practices associated with the topic in question – person-centred care – through which participants might reveal meanings and beliefs (Bevir & Rhodes, 2016).

Some weaknesses of interviews have been highlighted in methodological literature. For example, attempts to gather data on experiences during interview relied on participants' ability to relate their experience and effectively communicate those experiences (Polkinghorne, 2005). The mental labour asked of interviewees, such as narrating, listening, understanding, analysing, and remembering, could be demanding (Mason, 2018). This potential limitation may relate to research involving organisational and professional settings, given the tacit nature of learning practical skills in many occupations (Gherardi et al., 1998). I tried to address these issues through a range of techniques (see Chapter 4 and Section 9.5 of Chapter 9). Interpretive policy analysis is suited to interpreting underlying, tacit meanings from close analysis of data. One tradition that would enable examination of such meanings is the semi-structured interview: that is, one partly based on an interview schedule, with space and time allowed for unstructured, conversational discussion (Lichtman, 2014).

Existing literature in health and social care has shown semi-structured interviews to illuminate debate on policy implementation, through exploration of key actors' experiences. For example, older people who paid for care privately discussed processes of navigating the care sector in semi-structured interviews, with some stressing the need for familiarity and trust in the competence of care workers (Tanner et al., 2017). Semi-structured interviews were used with healthcare professionals to discuss their experiences of caring for older people with dementia living alone (de Witt & Ploeg, 2014). Participants described the difficulty of promoting client autonomy while ensuring safety (ibid). In light of the richness of these studies' findings, I believed semi-structured interviews would provide an effective vehicle to explore care staff's assumptions and perspectives relating to person-centred care.

I considered logistical methods for gathering sufficient data to answer the research questions. Remote interviewing, which involves communicating to participants via telephone or computer, and the merits of this, were considered alongside other forms of interview. Some believe face-to-face interviews and focus groups are the gold standard in qualitative data collection (Holstein & Gubrium, 2003). It has been argued face-to-face interviews are more conducive to natural responses, as the interactive setting would include more opportunities for small talk and humour (ibid). However, telephone and online interviews are not necessarily inferior to these methods (Braun et al., 2017). Both online interviewing, using video-conferencing software, and telephone interviewing, are synchronous – offering opportunity for real-time interaction between researcher and participants (Braun et al., 2017). Synchronous methods offer space for natural, free-flowing engagement and interaction, allowing both parties the opportunity to ask for clarification about something they did not understand. Video interviews have the advantage of allowing the researcher to see non-verbal cues, which are not available in telephone interviews (Fielding et al., 2008). It has been argued the quality of responses and rapport in online interviews was much the same compared to face-to-face methods (Deakin & Wakefield, 2013). Remote interviewing offers logistical benefits. It is cost-effective, eliminating travel costs and the issue of geographical distance associated with face-to-face meetings, allowing researchers to conduct interviews with people who might otherwise be difficult to reach (Fielding et al., 2008). It is convenient and flexible for both parties in terms of scheduling (Johnson, 2014). Telephone and online interviews offer an accessible, familiar space for participants, removing the need to travel to a researcher's office or having to invite a researcher into their home or place of work, which may feel uncomfortable or intimidating (Braun et al., 2017). Telephone is seen as a good format for semi-structured interviews, as the researcher or participant have equal opportunity to lead the conversation and there are opportunities to expand the discussion (Johnson, 2014). Video-conferencing software has this synchronous quality as well. These advantages, combined with constraints

placed on the research project by the COVID-19 pandemic, led to a decision to offer participants a choice of either telephone or online conversation.

The construction of the Interview topic guide is described in Chapter 4. The way in which data yielded from the interviews would be examined is explained in the section below.

3.10 Research design: thematic analysis and framework analysis

Qualitative analysis can be thought of as a sequence of categorisation procedures (Cardano, 2019). The activity begins with examining data and categorising their aspects one at a time; categories applied to a textual corpus and relationships between them are explored, leading to more complex categorisation forms (ibid). Commentators argue qualitative analysis offering mere description of the data is not enough: through detailed analysis, explanations of people's understandings and attribution of meaning to the social world could be generated (Ritchie et al., 2014). Such theories should be grounded in but go beyond the surface of data (Braun & Clarke, 2006). This process of scrutiny, categorisation, and theorisation, embodied what Mills (2000) described as the 'grammar' of sociological imagination (cited in Cardano, 2019). This section considers different attitudes towards qualitative scrutiny of data and presents a rationale for my chosen methods.

One of the stock materials in this grammar of sociology are themes, used by researchers to interpret data and identify patterns and potential meanings (Terry et al., 2017). Thematic analysis offers a process of identifying, analysing and reporting such patterns within qualitative data (Braun & Clarke, 2006). Within this approach, codes or labels are attributed to data. Through close analysis of data, researchers combine, cluster or collapse codes together into more meaningful patterns to construct themes (Terry et al., 2017). Theme definitions,

substantiated with data extracts, help to capture richness and diversity of meaning within the data (ibid). Thematic analysis has been praised for making a substantive contribution to qualitative analysis (Given, 2008). For example, it allows recognition of patterns of commonality across all cases and contextual aspects of the phenomenon, perhaps explaining differences among participant interpretations (ibid). Thematic analysis has been applied to conceptual studies of meaning and experiences in health and social care literature. For example, nursing home staff's views about their work were subjected to thematic analysis of interview transcripts (Pfefferle & Weinberg, 2008). It identified spiritual experiences in the discourse of participants, regarding caring for people with severe disabilities and witnessing resident death (ibid). Concerns have been raised about the application of the method in literature in recent years, however. Commentators suggested authors cited the term 'thematic analysis' without reference to its theoretical foundations, and used it to describe superficial analysis that was purely descriptive or summative in nature (Terry et al., 2017). The widespread use of thematic analytical techniques meant its qualities as a stand-alone method risked becoming diluted and contentious (Silver & Lewins, 2014). However, that did not necessarily expose weakness in the method itself – merely that some analyses had been poorly conducted (Braun & Clarke, 2006).

To provide sufficient analytic material to answer the research question, I planned to note associations within data relating to experiences, behaviours, perspectives, and outcomes (Ritchie et al., 2014, p285). I anticipated a need for close scrutiny of relationships between categories the formation of theories and explanations, as fractured data were put back together (Green & Thorogood, 2004, p182). It was necessary to move beyond description and categorisation and ask more complex questions by examining how codes and other parts of the data related to each other (ibid). In addition to categorising different phenomena within individual transcripts, therefore, I planned to perform cross-sectional qualitative analysis, involving review of the whole dataset. A cross-sectional approach would allow systematic coverage of data, identifying

thematic categories and patterns across different cases (Ritchie et al., 2014, p280). Such rigorous examination would add depth to analysis, revealing relationships between phenomena within a single case (or interview) and across several cases/interviews (ibid), allowing cross-references to be made between actions, behaviours, and participants' individual characteristics. It would lead to findings based on thorough examination of the research topic, while reflecting principles of interpretive policy analysis. Interpretive policy analytical frameworks assumed behaviours in relation to policy implementation were expressions of meaning (Wagenaar, 2011, p20). When it comes to studying meaning, there is no way around the rigorous examination of such acts in the research process (ibid).

Framework analysis offers a template for cross-sectional scrutiny of themes. This method has been viewed as a valuable tool for the systematic examination of data across large datasets (Gale et al., 2013). It is defined as the use of a matrix output, displaying data through rows, columns, and cells of summarised data (ibid). Rows might be allocated to cases, and columns to codes: this structured format offers a method for reducing or condensing data, allowing for analysis by case and by code (ibid). The 'charting' or matrix procedure provides a visual aid enabling examination of data extracts, so patterns and relationships both across and within cases might become visible (Green & Thorogood, 2004). It is a flexible method, capable of being adapted to a range of interpretivist logics without having allegiance to a particular philosophy (Gale et al., 2013). Several studies applied framework analysis in health and social care literature to gain insight into policy implementation. It was used to study healthcare workers' experiences on smoking cessation services (Campbell et al., 2016). The authors used matrices to manage, summarise, and interpret the data: views and experiences of each participant were mapped onto a framework matrix, which enabled patterns of distinctive viewpoints to be identified (ibid). The framework analysis found that new service could help engage women within discussions of smoking in pregnancy. The same method was applied to an evaluation of a food subsidy programme aimed at mothers with young children

(McFadden et al., 2014). It was based on qualitative research involving healthcare workers, advocacy groups, and women on low incomes. Framework analysis of a large, varied dataset identified concerns that the programme may have been compromised by administrative issues (ibid). These examples illustrated how policy research in health and social welfare has been aided by framework analysis, with its capacity for structured outputs of summarised data, enabling thoroughness of analysis across datasets (Gale et al., 2013). Commentators have highlighted practical issues related to framework analysis that could have implications for research. For example, it is more suited to data grouped around similar topics, rather than data that are highly heterogenous (Gale et al., 2013). Performing the method could be time-consuming and laborious (Mason et al., 2018). Producing matrices was one part of the process: data may still require more nuanced analysis before robust theoretical connections could be made (ibid).

I considered the strengths and weaknesses of both methods in the context of the research questions, which require examination of meanings within discourse. I anticipated the strengths of thematic analysis would help reflect the richness and diversity of meaning by highlighting key themes and concepts. I was interested in exploring linkages in the data; to find out how codes related to each other. The benefits of framework analysis were that matrices grouped according to theme could offer a clear, concise overview of the beliefs, behaviours, and values of all participants. It was suited to analysing large datasets in a clear, manageable way – given my dataset had hundreds of pages of transcripts, this benefit could not be ignored. I assumed the framework approach would help reveal conceptual complexity and thematic diversity, both within interviews and across participants, which may not have been obvious through thematic analysis alone. As such, the method reflected core principles of qualitative research in general, and more specifically, interpretive policy analysis. The application of framework analysis combined with thematic analysis was, in my estimation, likely to generate findings of depth, diversity and complexity – some of the hallmarks of quality in qualitative research (Seale et

al., 2004). The analytical elements of the research design attempted to facilitate exploration of meanings and local knowledge of participants – the core interests of interpretive policy analysis. Thematic analysis and framework analysis provided a platform for detailed consideration of the relationship between participant practices and beliefs, and interpretations of person-centred care. These analytical methods could also help scrutinise participants' local reasoning. This could be understood by locating people's viewpoints within a wider web of beliefs suggesting reasons for holding them (Bevir & Rhodes, 2005). By placing individual participants' beliefs in the context of other facets of the data, such as their experience, background, or values base, I could make sense of conceptualisations in coherent ways. Therefore I decided to use thematic analysis, complemented by framework analysis, as the main analytical templates, in a manner suited to the guiding principles of interpretive policy analysis.

Analysis helped generate lines of argument, as part of a comprehensive account of meanings in relation to person-centred care. This process required reflection on empirical logic and the substantiation of claims to knowledge, discussed below.

3.11 Validity and generalisability of claims

To conclude the current chapter's description of methodology, this section will discuss the validity and generalisability of claims made following analysis. It will begin with an acknowledgement of my position within the social world as researcher, and my efforts to increase the validity and quality of the research, before considering generalisability.

Commentators have highlighted the importance of reflexive attitudes in social sciences research. This argument was notable in studies influenced by interpretive stances, where there were no statistical analyses to perform and the

researcher's role was crucial in all stages of the process (Lichtman, 2014). Given an interpretivist standpoint was adopted for this project, as stated in Section 3.7, I needed to be aware of my own values and my view of how the world is known (ibid). The idea of reflexivity was borne out of acknowledgement that social research could not be carried out in an autonomous realm, insulated from the influence of the researcher's self and wider society (Blaikie & Priest, 2018, p44). As mentioned in the preface in Chapter 1, my status as a former support worker in social services, and perhaps my personality, could have influenced interactions with participants during interviews. I may have analysed data differently to, say, a person with disabilities who has experience of using services. Yet this potential for heterogenous responses to the same object of inquiry was not necessarily problematic. As commentators have argued, different interpretations could provide accurate but different constructions of the same stories (Charmaz, 2004). While acknowledging the subjectivity of the process, my intention was to adopt a critical approach towards data, producing knowledge by mediating between participants' language and social scientific terms (Blaikie & Priest, 2018). I applied systematic connection between data collection and the topic's research questions (Mason, 2018). When forming conclusions I reflected at length upon data and attempted to display argumentative logic transparently in my writing, in ways that readers could follow (Miller & Brewer, 2003). Conclusions were justified by available evidence; analysis included deliberate consideration of contradictory data, to review initial interpretations (Gilson et al, 2011). These approaches to enhance validity would hopefully address previous criticism of some qualitative literature, that it failed to present the full weight of evidence for conclusions and the processes by which they were reached (Bourgeault et al., 2010).

A related issue to validity is the generalisability of arguments emanating from research. Unlike positivist philosophies of social science, interpretivist attitudes do not claim to represent a universal vision of reality. Consequently, there is some debate about whether claims could be inferred from a single study to the characteristics of a wider social milieu (Tolley et al., 2016). Some commentators

have questioned whether any form of context-free generalisation is desirable (Guba & Lincoln, 1981). I accept one cannot plausibly argue that small, purposive samples would be representative of a large population, just as a large, random sample may not be suited to eliciting insights in an in-depth study of experience (Tolley et al., 2016). But some degree of generalisability is feasible within the interpretive policy analytical framework. Without any form of generalisation, interpretivism runs the risk of being seen as art, rather than science, because it fails to offer claims about the state of the wider social world (Williams, 2002). Social science authors in health and social care literature have taken an open-minded view regarding generalisation of findings. Erichsen et al. (2010) adopted interpretivist principles in their study of honesty in nursing, recruiting 16 nurse participants from two hospitals for qualitative interviews. Despite the limited sample, the authors extrapolated broad conclusions from the findings, producing skills guidance aimed at the nursing profession (ibid, p40). Needham (2013) stressed their sample of day centre workers was not intended to be representative of the whole sector, yet the study included statements comparing the phenomenon with literature about the wider sector. Similarly, Watson (2019) acknowledged findings from a study of relationships in care homes could not claim to be generalisable because fieldwork was conducted in a single home. Yet the study concluded with 'lessons learned', aimed at care professionals, extrapolated from the findings (ibid, p560). These examples from health and social care literature underline a general observation, that authors of many interpretive accounts infer findings about the wider world from idiographic accounts of a phenomenon, often tacitly so (Williams, 2002).

In the present study, social scientific theories of understanding person-centredness could contribute to debates on practice across the care sector. As Mason (2018, p113) suggests, the aim of qualitative research is to seek nuance, complexity, depth and ambivalence in data and argument. General conclusions will be drawn that, although derived from a limited number of context-specific experiences, could offer theoretical insights relating to wider debates (Gilson et al., 2011, p3).

3.12 Summary of key points

This chapter has provided a reflexive account of the methodological rationale for my project design. It has demonstrated understanding of specific methods for data collection and analysis and the implications of different approaches (Seale et al., 2004). The design incorporated perspectives of those tasked with delivering person-centred approaches— an actor-centred view of the policy landscape, assuming versions of reality were projected by taken-for-granted beliefs and practices in everyday work contexts. It was interested in policy implementation, after the passing of legislation and publication of guidance, and what happened as policy messages filtered through to the front line of practice with clients and citizens (Yanow, 2000). I aimed to utilise an interpretive policy analytical framework to examine local practices and knowledge linked to understandings of person-centred care. Local reasoning of care workers and managers, based on their beliefs and values (Bevir & Rhodes, 2016), would be crucial to producing insights about meaning.

A full outline of data collection and analysis methods, including a description of the sample of care workers and managers, is included in Chapter 4.

Chapter 4: **Methods**

4.1 Introduction

Chapters 1 – 2, containing discussion of key findings from academic literature and the policy landscape, provided a detailed outline of the research problem. Chapter 3 outlined philosophical debates informing the design of this study, and rationale behind the selected data collection and analytical methods. Following this explanation of key theoretical assumptions, this chapter describes the research activities and how they were conducted. One of the first considerations, which took place during early planning stages of research design, was ensuring fieldwork activities would be conducted inclusively and ethically. This is explained below.

4.2 Ethics and inclusivity

Scientific studies should be conducted so as to minimise the risk of harm to participants, by protecting privacy, gaining informed consent, and following basic principles of ethical social research (Bryman, 2015, p125). Ethical research, particularly in social policy topics, is distinguished by inclusivity. Engagement with voices from the front-line of public services could make policy more responsive and effective, according to advocates for interpretive policy analysis (Durose, 2007).

These principles of ethics and inclusivity were reflected in the study design. My decision to select front-line care workers and managers as key informants demonstrated an inclusive approach to policy research. For example,

participants were invited to take part in interviews using online technology or telephone. It was important to offer the latter as it was assumed most people would have access to a telephone, so as not to exclude people without access to a computer or the internet. People were given the chance to decide whether or not to take part in research with a full understanding of the implications, including any possible risks, based on the principle of informed consent (Babbie, 2016). Information sheets were distributed, explaining the rationale for the project, the time commitment involved, and how their data would be handled (see Appendix i). It explained people's right to withdraw and warned of possible risks, such as the interview touching on sensitive subjects. At the start of each interview I reiterated these points verbally, including the option of taking a break or finishing early if someone felt distressed or uncomfortable. The information sheet advised of possible benefits of taking part, such as the opportunity to contribute to debates on care policy. The information sheet complied with the UK General Data Protection Regulation, which is part of the Data Protection Act (2018), by describing how personal data would be stored. It included contact details for the University of Bristol's Data Protection Officer, the UK Information Commissioner, and my supervisors in the event of any complaints or queries. Consent forms were sent to participants (see Appendix ii); some people signed these and returned them prior to interview. If participants had not done this, consent questions were asked at the beginning of the interview. The audio recording of these questions and participants' answers were transcribed to record consent being given. The completed consent forms, along with interview data and participants' personal data, were saved on a secure server hosted by the University of Bristol. These steps all formed part of ethical requirements to gain informed consent and to protect people's privacy.

I ensured confidentiality to the participants, by ensuring real names were replaced by pseudonyms in the thesis and related reports. The names of clients were redacted from the thesis and replaced with pseudonyms, to protect their privacy. These steps were taken to guard against any concerns that people may have had about being harmed due to identification and inadvertent disclosure

(Babbie, 2016). In addition to the consideration of avoiding harm to participants, I considered the risks to myself as a researcher. This was because there were sometimes personal consequences to undertaking fieldwork on sensitive topics (de Laine, 2000). Each interview was due to take between 30 and 60 minutes. Although I anticipated some topics may become sensitive and distressing, the subject of care work was not inherently contentious or likely to cause distress, and I already had experience of working in similar settings in the past. Therefore, I anticipated the risk of psychological harm or exhaustion to myself was low.

Another consideration was the archiving of data, linked to my project being funded by the Economic and Social Research Council. This organisation's policy framework on data management included an expectation that funded projects' data would be made publicly available in a timely and responsible manner (Economic and Social Research Council, 2018). I decided to submit interview transcripts to the Research Data Repository, managed by the University of Bristol Research Data Service, at the conclusion of the project, to allow data to become available to other researchers in future.

An application for ethical approval was sent to the School for Policy Studies research ethics committee, University of Bristol, in October 2020. The application included a full research proposal explaining the rationale, and how the project would comply with legal and ethical requirements. Permission was granted on 10 November 2020 with suggestions for minor improvements. These included points such as the information sheets and consent forms explaining confidentiality more clearly, and to ask for specific consent that interview data would be archived. Revised materials were sent back to the committee, which were accepted. The content and format of the information sheet and consent form were finalised and double-checked for accuracy in light of the ethics committee's comments.

The next step was to invite people to take part in the study.

4.3 Recruitment of participants

Having gained ethical approval for the study, I needed to locate possible participants for interviews. As part of the recruitment process I used the Care Quality Commission website (Care Quality Commission, 2020) to source contact details for care home providers and community care organisations. I contacted the ENRICH (Enabling Research in Care Homes) network, operated by the National Institute for Health and Care Research (NIHR). I took part in a video meeting with a research officer at NIHR West of England to ask for support in finding willing participants in care homes; the officer circulated an email among care home managers asking for cooperation on my behalf. I accessed 15 websites operated by local authorities across England with directories of personal assistants advertising their services. These included directories such as Bracknell Forest Support with Confidence (2020), North Somerset Online Directory (2020), and Notts Help Yourself (2020). I contacted around 50 care home providers, ten community care providers and 45 personal assistants to invite them to participate in my research project. At this stage I called the listed telephone number or sent an introductory message by email to the organisation or individual worker. The message would include the information sheet and consent form as attachments, plus a short email introducing myself and the project, saying it would involve participating in an interview by telephone or online. The majority of those contacted did not respond or declined to participate; some cited time constraints. In some cases, when discussing my project with personal assistants I decided not to proceed with the request if it appeared they did not have relevant experience. In cases where care home providers or community care organisations agreed to participate, I asked for help in nominating a staff member to participate in the interview.

The development of the interview guide and conducting of interviews during fieldwork are described below.

4.4 Conducting interviews with care workers and managers

The interviews were semi-structured, as explained in Chapter 3. An interview schedule (see Appendix iii) was developed to explore people's perceptions and understanding of person-centred care from different angles, informed by literature reviews discussed in previous chapters. A draft schedule was piloted with two colleagues in separate telephone conversations. This process provided useful feedback, later incorporated into a revised draft of the schedule, such as reducing the number of leading questions and grouping questions with similar subject matter alongside each other. The final version of the schedule began with introductory questions asking about people's qualifications and years of experience. At the beginning of each interview I also tried to include at least one or two straightforward, non-threatening questions to build rapport, establish common ground, and engage the participant, as suggested by research methods literature (Bourgeault et al., 2010). These included questions such as: 'Do you enjoy working with older people' and 'What do you enjoy most about working with older people?' The first, substantive question then followed: 'What does person-centred care mean to you?' This appeared to be an important question in the context of my aim of exploring meanings of person-centred care, and helped orient the interviewee to the central research topic. It was important to note the latent qualities of meanings, which were often known tacitly (Yanow, 2000, p15), as discussed in Chapter 3. Therefore, I tried to ascertain people's reasonings by focusing on events and situations, as suggested by Mason (2018, p110). I did this by asking participants to offer examples of when they felt they had delivered person-centred care to a client, alongside questions about related training and literature. Another research aim was to examine the relationship between policy and practice. To this end, one of the questions

involved reading out the Care Certificate definition of person-centred care (see Section 1.4 of Chapter 1) and asking participants for their views on this explanation and whether any values stood out for them. This line of questioning was intended to elicit interpretations of policy guidance and local knowledge about person-centred policies, which would enable comparison of actors' interpretations of the policy and the original intentions of policy-makers (Yanow, 2000, p74).

Another way to elicit people's reasoning about potentially abstract themes is by giving them scenarios or vignettes to respond to (Mason, 2018). Vignettes have been used in social science studies regarding professional services to simulate scenarios with abstract themes and dilemmas, which has the benefit of encouraging professionals to share practical experiences (Allen et al., 2013). Therefore, I constructed a vignette involving a fictional client to establish how they might approach a practical scenario which resonated with the research questions. The vignette involved a description of a client with dementia, read out to each participant during interview, with a follow-up question: 'How would you support this client in a person-centred way?' The vignette was altered slightly depending on whether the participant worked in residential or community care. Both versions of the vignette are presented below:

For staff working in community care:

"Linda is 85, lives alone in a house on the outskirts of town. She has had dementia for five years and recently her memory began deteriorating more rapidly. For example, she sometimes forgets where her clothes are kept. Linda walks with a frame due to arthritis and dizziness. She has two grown-up sons who live far away and don't want to expose Linda to the risk of COVID so don't often visit but stay in touch by Skype. You don't know much about Linda as a person other than she doesn't like tea and enjoys fresh air and gardening, and has been on her own since her husband passed away ten years ago."

For staff working in residential care:

“Linda is 85, until last year she lived on her own in the community, and has dementia. When her memory started deteriorating more rapidly, she moved to a care home. Memory loss has affected her in different ways, for example she sometimes forgets where her clothes are kept. Linda walks with a frame due to arthritis and dizziness. She has two grown-up sons but they live far away and don’t want to expose Linda to the risk of COVID infection so haven’t been able to visit much this year and keep in touch by Skype. You don’t know much about Linda as a person other than she doesn’t like tea and enjoys fresh air and gardening, and lived on her own for several years after her husband passed away.”

Figure 4.1: Vignettes included in interview schedule

The semi-structured interview allowed each participant to be asked roughly the same questions, with the opportunity to probe and ask subjects to elaborate, by asking for examples or asking what they meant by something. I attempted to listen attentively and ask for clarification if an utterance was not clear. The method allowed time for conversations to develop naturally, allowing for deeper exploration of meaning, while providing a structure of specific themes and questions. The (mostly) uniform nature of the interviews meant comparisons could be made across the dataset regarding specific themes and beliefs (Bourgeault et al., 2010). The semi-structured format was in keeping with the idea that the interview was a form of social interaction, and it was acceptable to deviate from the topic guide occasionally (ibid).

Online interviews were facilitated through Microsoft Teams, which allowed for video-conferencing conversations, with both video and audio. There were recorded on a video file on the computer via MS Teams automatically. I recorded telephone interviews with an audio recorder linked to the telephone, and uploaded audio files to the computer manually.

Justification for the cohort’s sample size is described below.

4.5 Assessing project sample size

The amount and depth of data needed for any project depends on its aims and objectives. Given my objective of studying meanings and interpretations of person-centred care from the perspective of workers and managers, I planned to continue conducting interviews until reaching the point of conceptual saturation - that is, where further interviews yield little new knowledge (Brinkmann & Kvale, 2018). This logic was based on the idea of diminishing returns: there would come a point when additional interviews would become less and less valuable. After making numerous enquiries to potential participants, I had received seven positive responses from care home providers, six from community care providers, and eight from personal assistants. This led to 22 arranged interviews. One interview was aborted because the participant felt unwell early in the discussion; another was cancelled because a participant was on sick leave, resulting in 20 completed interviews. Having completed these interviews - eight with managers and 12 with care workers - I felt further data collection would have contributed little in the way of original insights in the context of a precisely worded interview schedule.

This decision was verified by cross-referencing the development of new codes against chronological analysis of individual transcripts. Developing codes in relation to the data was an important part of thematic analysis (see Section 4.7). This process involved labelling different parts of the data with a code, and categorising segments of transcripts as relating to a more general idea, theme or category (Silver & Lewins, 2014). The table below tracks development of new or unique codes as analysis progressed. Each participant was given a reference number, which advanced in chronological order as each new transcript was coded. Reference numbers were given different prefixes: 'CW' for care workers and 'CM' for managers. The table is ordered chronologically in the first column to represent the order in which the interviews, and subsequent analyses, were carried out: CW001 was the first interview, followed by CW002, and so on. The

second column represents the number of unique codes identified from analysis of the relevant transcript.

Transcript reference no.	New codes identified
CW001	30
CW002	5
CW003	4
CW004	4
CW005	2
CM001	5
CM002	4
CW006	1
CW007	1
CW008	1
CW009	0
CW010	2
CW011	3
CW012	2
CM003	1
CM004	2
CM005	0
CM006	2
CM007	0
CM008	0

Figure 4.2: Identification of new codes in relation to each interview, in chronological order of interview completion

The highest number of new codes were generated during analysis of the first transcript, identifying 30 codes. This number dropped significantly between initial analysis of the first and second transcript and remained at five or fewer for each subsequent transcript. Analysis of the final four transcripts yielded only

two new codes between them. The limited number of new themes identified in the final few transcripts prompted my decision to conclude data collection. (These considerations were balanced alongside the time available within the PhD programme.)

A related aspect of these research activities was transcription, which formed an early part of data analysis.

4.6 First stages of data analysis: transcription and saving data to NVivo

When planning the fieldwork, I decided a complete written record of interviews would be crucial for analysis. This enables interview transcripts to be included within the thesis as appendices, to enable transparency in my presentation of research (Flick, 2018a). Although a time-consuming process, I decided transcription would be a useful way to increase familiarity with the data and form the first stage of analysis, as noted by Allen (2018). For these reasons data analysis included full transcription of the interview recordings, which I carried out myself, manually, with a computer and electronic foot pedal.

The transcription style was broadly naturalistic. It captured the flow of conversation with a verbatim record of speech by both interviewer and participant (denoted as 'I' and 'P' respectively). Some transcription styles include prosodic detail: components of speech relating to pitch, tone, and so on (Flick, 2014b). I used exclamation marks at the end of a sentence where a participant raised their voice or sounded excited. Some pauses were marked in brackets when there was a gap of more than a couple of seconds, to indicate where participants may have hesitated. Beyond this, I decided against including further prosodic detail, because my analytical methods concentrated on themes expressed by participants rather than exact depictions of how something was said. At times, a participant's speech was inaudible. Rather than guess a word

or leave a break in the transcription, I noted the point in square brackets to demonstrate inaudible speech (Bird, 2005). Participants' grammar was not altered in any way. Transcription was usually carried out within a week of the interview in question, or occasionally the day afterwards; doing so in a timely manner is considered good practice because it helps ensure accuracy (Flick, 2018b). Transcripts were typed into Word documents and saved securely on a remote drive.

QSR NVivo 12, a software package for qualitative research, was used to assist with qualitative analysis. This had capacity to handle large datasets by importing documents, label data extracts with thematic codes or 'nodes', and examine relationships through matrices of coding and text (Jupp, 2006). Given the size of the dataset, NVivo could conduct queries across all transcripts and facilitate speedy retrieval of coded data. NVivo includes powerful mapping tools to facilitate analysis of individual codes, offering cross-sectional pictures of relationships between themes and participants (Silver & Lewins, 2014). These functions were suited to the analytical aims of the project: interpreting participants' beliefs and perceptions regarding person-centred care. Interview transcripts were uploaded into an NVivo project file and saved on a computer.

Approaches used to interrogate data were thematic analysis and framework analysis, as discussed in Chapter 3. The steps taken within this part of the research are discussed below.

4.7 Latter stages of data analysis: conducting thematic analysis

After completing transcription I undertook thematic analysis for this project in three stages: familiarisation, initial coding, and in-depth coding. Each stage is described in detail here.

i) Familiarisation and pen-pictures

Familiarisation is seen by methodological commentators as a crucial stage of thematic analysis. At this point, researchers get to know the data, noticing patterns and quirks, learning about assumptions and worldviews of participants (Terry et al., 2017). For the familiarisation stage I read all transcripts several times and listened to recordings to study participants' language, phrases and meanings. I paid attention to how people talked about themselves, their clients, care work, and the concept of person-centred care, making notes throughout. Pen-pictures were used as a tool to understand perceptions and reasonings of individual participants. This process involved reading an individual transcript in its entirety and highlighting key phrases which touched on values and interpretations of person-centred care. I collated relevant extracts into logical order and combined them into a single document, written in the first person, of around one or two A4 sheets, providing a succinct description of a person's account in their own words. Pen pictures were verbatim extracts from the data, with some editing for clarity and length. They typically started with a brief explanation of the person's professional background and role, included comments about their job, interactions with clients, and understanding of person-centred care. This was an important part of familiarisation, allowing the identification of contrasting interpretations of person-centred care alongside individual characteristics. Not all of them were included in the final thesis; however, some pen-pictures can help bring the participants to life for the reader (Hollway & Jefferson, 2000). Therefore, in the final thesis I included three pen-pictures, each describing a different interviewee, in the findings chapters. This enabled readers to gain a concise overview of participants' perceptions and backgrounds, without having to undertake the time-consuming process of reading full transcripts (ibid).

ii) Initial data coding

One of the first steps of analysis was to parse data into codes, representing an individual category or theme. Coding incorporated indexing and sorting, one of the early steps of thematic analysis. The aim was to decide which parts of data were about the same thing and belonged together (Ritchie et al., 2014, p282). In practical terms, this meant analysing the 20 transcripts to identify and label different phenomena within the data. Labels were assigned using the coding function of NVivo, which allowed exemplar data for specific codes to be retrieved at a later stage. A broad-brush coding strategy was adopted to cover many aspects of care work visible in the data. This involved the coding of seemingly innocuous phenomena, even if it wasn't immediately relevant to an understanding of person-centred care, to allow for the possibility that its relevance may become more established as analysis unfolded.

Some of this involved *in vivo* coding, in which vocabulary used for coding was taken directly from the participants' language (Ritchie et al., 2014). For example, one of the participants commented on her approach to communicating with clients:

So they're shouting, screaming, they're in pain, they're crying, and yeah, like you said, some people, you've got to have patience. That's the other thing, isn't it...That's a very, very big one, especially with dementia, is patience."
Jackie, CW002, community care worker

The participant's use of the word 'patience' led to the introduction of a code with the same name. This was an example of an *in vivo* code. At other times the concepts were *emergent*, that is, they were observed in the data but devised by the researcher to reflect the essence of the participant's talk (Ritchie et al., 2014, p272). One example was seen in the following extract from the dataset:

Oh definitely, you know a lot of people like maybe the younger ones [laughs] and then they like the old birds like me! But yeah, we've got a gentleman, especially one gentleman who prefers to see me because he likes my medical knowledge, and it

alleviates his fears and his worries and his anxieties about his health. And he always feels more relaxed when I visit because he knows he can talk to me about those things.

Lucinda, CW004, community care manager

Here, the participant's warm, familiar tone, visible in phrases like 'he always feels more relaxed', conveyed a sense of mutual trust and the idea that Lucinda and her client were comfortable in each other's presence. Lucinda said she used her professional knowledge, gained during nurse training, to minimise the man's anxieties about medical issues. The self-deprecating comment about 'old birds like me' implied an affinity with some clients, who liked the fact Lucinda was middle-aged. The implication was trust and attachment had developed between the two parties, which led to this extract being labelled as 'building rapport'. This was an example of an emergent concept: the word 'rapport' did not appear in this extract but was inferred by language within the data. These deductions guided the coding of the whole dataset.

I developed thoughts by writing memos at the end of each day of coding. For example, these were the notes after one of the early sessions:

- *Changed 'problem s'lvln' to 'initiative'*
- *Deleted 'decision 'aking' node and moved some of references to 'initiative'. (Decision making too vague)*
- *May need to recode 'barriers to person-centred' care' with additional sub-codes*
- *Added code, 'monitoring client safety'*
- *Added code, 'quarantine or iso'ation' under COVID restrictions*
- *Added code, Role play, imagining client's perspective*
- *Added code, Social distancing, under COVID restrictions*

(Coding memo, 6 February 2021)

As these bullet points illustrated, the types of codes included gerunds, e.g. 'monitoring client safety', and conceptual headings, ranging from broad themes such as barriers to person-centred care, to more circumstantial issues regarding the COVID-19 pandemic. The initial coding process led to the development of a coding frame including major thematic categories and sub-categories, with several dozen themes in total.

iii) In-depth data coding

A provisional coding frame was revised multiple times during in-depth coding. In these secondary rounds, concepts were parsed, resolved and tested through examination of participants' language and phrasing at granular level. During this process, some codes were merged and redundant ones deleted as meanings became clearer. Some themes expanded as broad categories were divided into more specific labels. For example, one of the areas relevant to the research questions was 'skills'. I tried to break this down into more specific labels relating to the type of skills shown in the data. This approach led to the development of a more detailed group of codes linked to observation, assessment, and communication. The latter category, communication, was parsed into sub-categories, such as 'asking client questions', 'listening to client', and 'tailoring communication to client'. This coding produced examples which, in context of the policy situation, could have been linked to local reasoning and knowledge (Yanow, 2000). In turn, this knowledge would offer insight into participants' values, beliefs and practices underpinning an understanding of person-centred care.

Analysis in these stages was cross-sectional in approach, with continual revisions to the coding frame during the indexing process. To aid collation of data, codes were collapsed into overarching categories in NVivo using the 'node folder' function. The procedure for each round of coding and indexing involved the following systematic steps:

- *Read transcripts;*
- *Create codes in NVivo;*
- *Annotate transcripts and assign extracts to codes using the 'analyze' functions in NVivo;*
- *Revise coding frame;*
- *Re-read transcripts;*
- *Begin coding all transcripts again to ensure all extracts related to new codes formulated in previous round of coding are assigned retrospectively.*

This process was repeated five or six times, to take account of revisions to the coding frame as new or revised codes had to be applied to the dataset retrospectively. These steps concluded the thematic analysis stage, which provided a solid foundation for the framework analysis performed next.

4.8 Latter stages of data analysis: conducting framework analysis

Thematic coding grouped different parts of the data according to ideas and categories. Results of this thematic analysis gave an overview of recurring values and beliefs within the transcripts. In order to compare themes across interviews in a clear and transparent way, framework analysis was used (as discussed in Chapter 3). I conducted this procedure in three stages: i) charting, ii) annotation, and iii) reviewing of associations. The procedure was loosely based on a design set out by Gale et al. (2013).

The first step, charting, involved collating coded data extracts into a series of tables in Microsoft Word grouped around themes identified during thematic analysis. Charting allowed comparison of themes across and within interviews. Typically, a table would have 40 – 80 rows: between two and four rows for each of the 20 participants (the number of rows would depend on the number of relevant data extracts for each individual), and four columns for data extracts.

Each table would cover a central theme. During the second stage, I read the material in the tables and annotated each extract with a key quotation (verbatim, from the data) or extrapolation (with my own reflections) to highlight meanings, behaviours, and messages. I read data extracts several times and wrote memos in NVivo to reflect on strategies and philosophies regarding understanding and implementing person-centred care. I created around 20 tables covering different values, beliefs, aspects of practice and person-centred attitudes. An example of one of the tables is shown in Figure 4.3 below.

					another rant, don't let me get carried on that.	
				Self-awareness	Enormous benefit to mental health	I've learned a lot from my clients as well...which is marvellous
5. Community care worker	Matthew	CW005	Personal assistant, SE	P. Through those early, those early experiences of allowing clients to take risks were I guess formative for me. And they helped me develop my own standards of care behaviour. I wasn't sure if, how much I would enjoy working in the care industry but it's been surprise – I mean, lots of people say, 'it's very rewarding.' But actually it's very stimulating, it's very hard.	Sure, OK. And do you enjoy working with older people generally? P: Yes I do, I mean I'm sixty-three so I'm, probably older than the typical carer although there are plenty of other sixty, sixty-somethings working in the care industry. So I think they see me as somebody more like them, which makes them more accepting of me. I can talk about things from my childhood which resonate with things from their childhood so that, that gives a kind of feeling of affinity. And by and large, y'know, anybody would enjoy working with somebody who is polite, pleasant, appreciative, thoughtful, and that's what I see working with older people, I see that kind of appreciation and respect.	You...am I answering this in the right way. I mean there's a lot of easier ones, so: have I got a level of empathy, have I got a good sense of humour. Can I show that I'm interested in people. Do I actually care about this person that I'm providing care services to, or am I just doing a job? So those, those are the sort of easier ones, I'm sure you'll get a lot of that. But what I was trying to express was...[pause] If I take a, y'know, if I take what somebody else might think of as a risk, with a client it's not me taking the risk it's the client taking the risk, and me feeling that I can confidently support them while they take that risk, so there's a, there's a quality of confidence I think that you need. And if you don't have that confidence I think it can compromise your ability to deliver person-centred care as I see it.
				Developing own standards of care	Feeling of affinity with older people due to being older himself	Do I actually care about people? Attitudes of care worker

Figure 4.3: part of a framework analysis table

This table included some of my reflections on the data. A quote by one participant, shown in Figure 4.3, discussed developing personal standards of care behaviour. In the cell below, I annotated this extract with the comment: 'Developing own standards of care'. This was an example of data interpretation, one of the key steps of framework analysis: impressions and ideas should be noted in order to recognise characteristics of and differences between the data (Gale et al., 2013).

In the final stage, reviewing associations, I used NVivo to analyse the extracts and reveal thematic connections and patterns between themes and individual participant characteristics. The aim was to identify thematic coalescence around an overall philosophy or strategy towards care work with older people and person-centred care. Using NVivo's 'coding query' function, single transcripts were selected individually; coding frequency queries were run to check each participant's data against selected codes in the framework. In practice, I used this procedure in NVivo:

- *Explore tab, click Queries > Coding*
- *Select individual transcript*
- *Define criteria by selecting code of interest (coded at 'any of these nodes')*
- *Run query*

Results would typically look like Figure 4.4 (a screenshot of query results from NVivo):

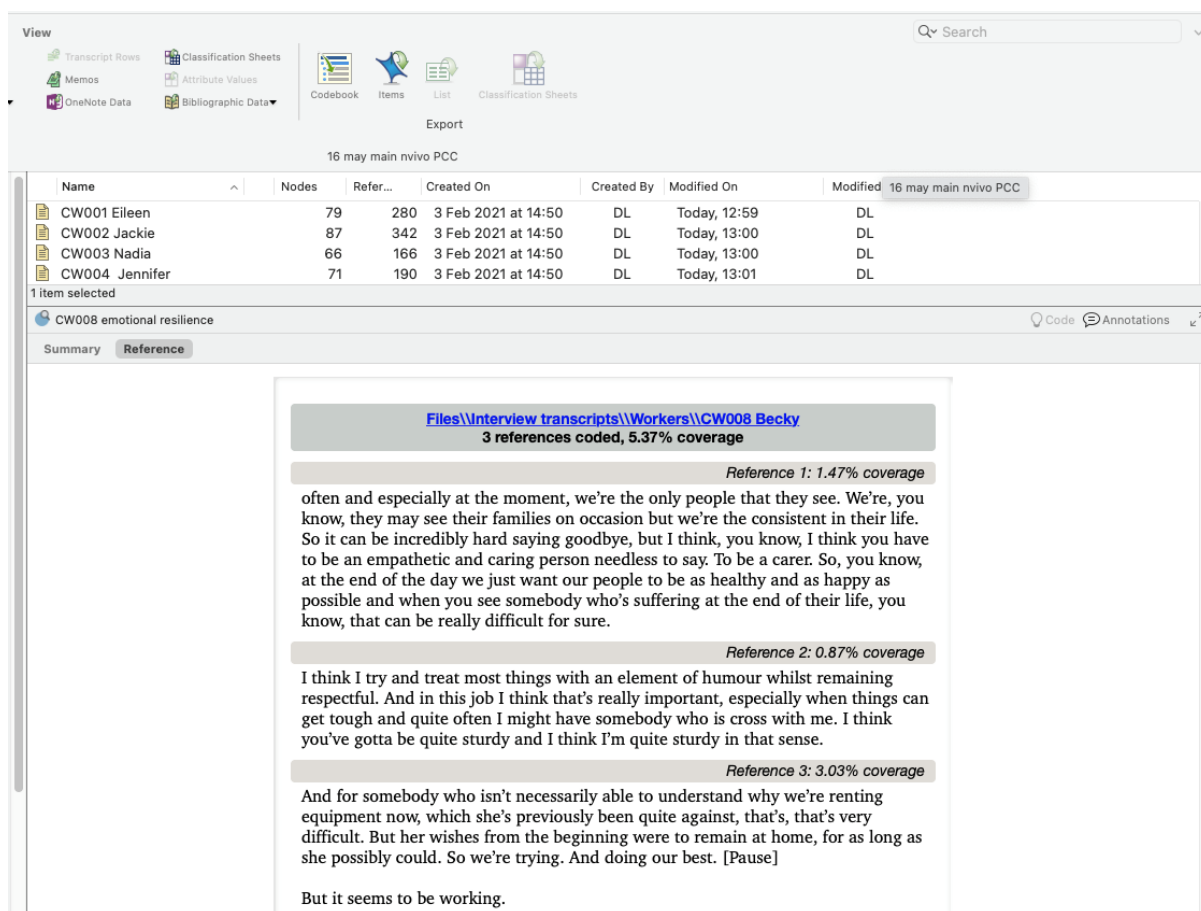


Figure 4.4: screenshot of NVivo, results of singular coding query

This screenshot shows results of a query relating to a specific code, 'emotional resilience', and some examples of related data extracts supporting the code under a tab marked 'reference'. During this stage of analysis, outputs from NVivo were combined with thematic charts in MS Word in order to map connections between categories to explore relationships between themes and participants (Gale et al., 2013). I recorded findings from these queries in a notebook, with numbers of references for each participant relating to different themes. A series of tables (which I called 'reference tables') were created under the headings of different themes. When one theme appeared to feature prominently in data for an individual participant, this participant's name was added to the relevant table for the corresponding theme. The process was repeated numerous times for different parts of the dataset, and involved development of groups of participants in relation to particular themes and

characteristics. This helped to increase my understanding of different facets of the participants' understandings and approaches to person-centred care.

In the final stages of analysis I consolidated connections across different parts of the dataset. I developed findings by constructing multiple-linkage typologies: this is where people or phenomena are classified in terms of unique clusters of characteristics (Ritchie et al., 2014). These classifications were identified through close examination of participants' language, and represented the beliefs, values and practices held by groups within the cohort in relation to the policy topic in question – in this case, person-centred care. As Yanow (2000, p9) argues, examining and categorising dimensions of data can help interpretive policy analysts understand the values, beliefs, and feelings that bind people together in communities of meaning. This can help synthesise different arguments about a policy issue, or reframe the debate at another level (ibid).

4.9 Summary of key points

This chapter has provided a transparent account of fieldwork and analytical activities undertaken. It is intended to increase validity by explaining how methodological principles were applied to empirical study. One of the principles of qualitative research is to demonstrate understanding of context (Seale et al., 2004). This chapter illustrates how this notion was embedded in the research design. For example, in asking participants about their experiences in the care sector, their professional backgrounds, and the clients they supported, I gathered details about their working contexts. This knowledge could help shed light on interpretations of person-centred practice. From an interpretive policy analytical perspective, it was important to attempt to locate people's viewpoints within a wider web of beliefs (Bevir & Rhodes, 2005), as noted in Chapter 3. I wanted to make sense of the whole dataset, using thematic analysis to gain a broad understanding of values and actions, and framework analysis to compare those values within and between individual transcripts. These features of

rigorous qualitative analysis can help maximise research validity (Green & Thorogood, 2004).

The remainder of the thesis presents the findings of the research, beginning with Chapter 5, which introduces the participants and presents initial perceptions of person-centred care.

Chapter 5: Findings: Overview of participants and initial interpretations of person-centred care

[P]olicies are developed on the basis of argumentation, ideology and emotion as well as formal evidence. Scholars of public policy, people using services and frontline practitioners all bring their own interpretive lenses....

(Needham & Glasby, 2014, p24)

5.1 Introduction

As noted in Chapters 1 and 2, the views of care professionals were often neglected in public debate, in spite of their unique insights into policy and social issues. Perhaps in response to this oversight, Needham and Glasby (2014) positioned front-line practitioners as critical actors in a landmark study on person-centred approaches in adult care, from which the above quotation is taken. In this passage, the authors afford equal importance to professionals, scholars and people using services, and the meaning these actors assigned to policy. The lenses through which concepts such as person-centred care were viewed may have been developed by formal evidence such as employer-led policies, training programmes, and national standards, on one hand. On the other, softer evidence, such as beliefs, values, even emotions, as Needham and Glasby suggested, may have had some influence. Intersections of such perspectives among workers and managers resulted in practice-focused

interpretations of person-centred approaches, grounded in realities of everyday care and support for older people.

This chapter introduces the research findings. The aim is to cast colour and light on participants' interpretive lenses, and expose the diversity of their beliefs, values and practices, with respect to understandings and implementations of person-centred care. The first half of this chapter adds context to participant interpretations by presenting details about the care settings in which participants worked, opening with an overview of care professionals' training and experience. There follows contextual information about roles, responsibilities, and client groups, alongside a breakdown of sources of knowledge regarding person-centred care. The second half of the chapter is more discursive, offering accounts of what participants said about person-centred care and how they said it. The discussion focuses on prompted depictions of person-centred care – how participants described the concept when prompted by the interviewer - supported by interview extracts.

5.2 Characteristics of participants, settings, and client groups

People were invited to be interviewed for the project if they met the selection criteria: being a care worker or manager specialising in older people's care, with at least one year's experience, and based in England. A central theme characterised the work of all participants: supporting older people with care needs within the English care sector. In an interpretive policy analysis sense, they represented a community of meaning (Yanow, 2000). Within the group there was substantial heterogeneity, however. Job titles and roles differed according to the participant's individual circumstances and employment arrangements. This section describes the similarities and differences of the cohort's characteristics, with a nod to the practical implications of distinctive roles.

As stated in Section 4.5 of Chapter 4, 20 one-to-one interviews with care professionals were completed. MS Teams interviews, involving video and audio, were conducted with three participants: Jennifer (CW004), Matthew (CW005), and Kelly (CM001). The remainder of the interviews (17) were conducted by telephone. Roles and ages of participants, and settings in which they worked, are shown in this table (pseudonyms have been applied).

Table 5.1: Participants' roles, settings, and ages

Part- icipant number	Name	Role	Employer	Region of England	Gender	Age
Community care workers						
CW001	Eileen	Personal assistant	Self-employed	South West	Female	60s
CW002	Jackie	Care worker	Self-employed	South West	Female	30s
CW003	Nadia	Carer	Self-employed	South West	Female	30s
CW004	Jennifer	Personal assistant	Self-employed	East Midlands	Female	40s
CW005	Matthew	Personal assistant	Self-employed	South West	Male	60s
CW006	Maggie	Carer	Self-employed	South West	Female	60s
CW008	Becky	Care worker	Domiciliary care agency	South West	Female	20s
CW010	Nicola	Care worker	Domiciliary care agency	London	Female	50s
CW011	Elena	Care worker	Self-employed	South West	Female	40s
Community care managers						
CW012	Daisy	Shift co-ordinator & part-time care worker	Domiciliary care agency & self-employed	South West	Female	30s

CM002	Steve	Managing director	Domiciliary care provider	South West	Male	50s
CM003	Charlotte	Duty manager	Domiciliary care provider	South West	Female	50s
CM004	Lucinda	Supervisor	Domiciliary care provider	South West	Female	50s
Residential care workers						
CW007	Faith	Care worker	Nursing home	South West	Female	40s
CW009	Sarah	Senior care worker	Residential care home	South West	Female	30s
Residential care managers						
CM001	Kelly	Manager	Nursing home	West Midlands	Female	50s
CM005	Victoria	Registered manager	Nursing home	South West	Female	50s
CM006	Melissa	Registered manager	Nursing home	South West	Female	50s
CM007	Louise	Registered manager	Residential care home	South West	Female	50s
CM008	Samantha	Compliance manager	Residential care provider	South West	Female	40s

The table above shows the breadth and diversity of professional roles. Seniority ranged from junior care assistant to senior manager. Thirteen professionals – nine workers and four –managers - worked in community care, meaning they either visited older people in their homes or managed these services. Seven worked in resident–al care - five managers and two workers. Seven of the workers were self-employed, all of whom worked in community care. The remainder – two community care workers and two residential workers – were employed by provider organisations, along with all managers. Both residential workers and four of the five residential managers were permanently assigned to a single care home. The remaining residential manager, Samantha (CM008), oversaw a company’s care home services in multiple locations to ensure regulations were being met. Ages ranged from 20s to 60s, and the majority (17) resided in South West England, the remainder in other parts of England.

Job titles depicted in Table 5.1 were recorded verbatim from participants' interview data. Of the community care workers who were self-employed, three referred to themselves as personal assistants (Eileen, CW001; Jennifer, CW004; and Matthew, CW005), two as private carers (Jackie, CW002 and Elena, CW011), one as a self-employed carer (Nadia, CW003) and one simply as a carer (Maggie, CW006). The remaining community care workers, employed by agencies, described themselves respectively as a personal care assistant (Nicola, CW010), and carer (Becky, CW008). Of the residential care workers, one described herself as a care worker (Sarah, CW009) and another as a care assistant and shift leader (Faith, CW007). It was anticipated the beliefs and values of staff working for organisations, such as Faith and Becky, may have been influenced by employers' interpretations of person-centred care through training and supervision. The impact of training and development on self-employed staff may have been less pronounced, given their status of being on the periphery of the sector, outside institutional frameworks such as provider organisations. (The qualification levels of participants are presented in Section 5.4, below.)

Participants said their clients were mostly older people, alongside client groups with other characteristics. More information about the people with whom interviewees worked is outlined in Table 5.2, below.

Table 5.2: Client groups supported by participants

Community care workers	Participant no.	Name	Client group
	CW001	Eileen	Older adults, people with disabilities, substance misuse
	CW002	Jackie	Older adults and younger adults with disabilities
	CW003	Nadia	Older adults and younger adults with disabilities
	CW004	Jennifer	Older adults and younger adults with disabilities

	CW005	Matthew	Older adults and people with disabilities
	CW006	Maggie	Older adults
	CW008	Becky	Adults aged 50 and over
	CW010	Nicola	Older adults and people with mental health problems
	CW011	Elena	Older adults and people with spinal cord injuries
Community care managers	CW012	Daisy	Older adults and people with disabilities
	CM002	Steve	Adults aged 50 and over
	CM003	Charlotte	Older adults
	CM004	Lucinda	Older adults and people with disabilities
Residential care workers	CW007	Faith	Older adults, people with dementia
	CW009	Sarah	Older adults, people with dementia
Residential care managers	CM001	Kelly	Military veterans and their dependents aged 50 and over, people with dementia
	CM005	Victoria	Older adults
	CM006	Melissa	Older adults, people with dementia
	CM007	Louise	Older adults, people with dementia
	CM008	Samantha	Older adults, people with dementia

Findings suggested client ages ranged from 50s to more than 100 years old. Care needs were generally related to physical and cognitive impairment caused by illness or disability. Some settings focused on people with distinctive needs, such as military veterans and people with dementia.

During interviews, I asked participants about their roles and responsibilities. Roles of workers included assessing needs of clients, writing care plans, and providing personal care. Elements of personal care included assisting with eating, toileting, bathing, dressing, taking medication, and in some cases, food and drink preparation. Workers talked about encouraging the client to engage with the wider community, for example, by accompanying them to do grocery shopping. Participants facilitated activities to encourage clients to enjoy themselves and relax. Activities could involve community excursions, such as accompanying the client to a coffee shop or park, or indoor activities such as board games. The three participants who described themselves as personal

assistants (Eileen, CW001; Jennifer, CW004; and Matthew, CW005) said there was less emphasis on personal care in their work, and more on befriending, activities, and administrative tasks such as personal finance. However, there was some fluidity within some of the roles: for example, Eileen (CW001) described herself as a personal assistant with a strong focus on befriending, while supporting some clients with bathing and other aspects of personal care. Nadia (CW004) provided full personal care to some clients, and only befriending services to others. For the sake of clarity and given the loose distinction between the roles, all of the interviewees who were workers, not employed in a managerial capacity, whether they described themselves as personal assistants or carers, are referred to as 'care workers'.

Managers did not typically provide care themselves unless unexpected circumstances arose, such as staff absence through sickness. When discussing their roles, there was some overlap with care work tasks, such as liaising with clients' families and care planning. In addition to these duties, managers said they held higher-level responsibilities such as implementing national and local policies and procedures, ensuring the safety of clients and staff, keeping records, line management, and training and developing staff.

The participants all worked in the English care sector, where person-centred care was a central theme within legislation and guidance. The cohort represented diversity across different facets of employment: there were some professionals employed by provider organisations while others were self-employed; there was a variety of care settings; and differing levels of seniority, from junior assistants to senior managers. As explained in Section 3.8 of Chapter 3, this blend of responsibilities and employment arrangements had potential to add variety to the project's dataset.

Having introduced the cohort, it would be instructive to consider how individual professionals approached interactions with potential clients, and the implications those conversations had for person-centred care.

5.3 Acquiring new clients in a person-centred manner

Data included numerous references to administrative practices in which participants and organisations acquired new clients. These parts of interviews offered insights into person-centred attitudes, which some professionals tried to cultivate from the first meeting with a potential client.

When participants came across a potential client, they considered their needs and capability to support them. One of the most obvious administrative issues was whether the professional or provider had capacity to add to their existing roster. Eileen said she received interest from local authority social services departments when she advertised online, and described a typical initial conversation.

So from there on, from time to time you'll get a call from social services, 'Have you got any, any time, you know, that you could go and see this person'.

Eileen, CW001, community care worker

The reference to time in this reported conversation by Eileen – ‘Have you got any time...’ - suggested staff may sometimes have been too busy to acquire new clients. The depiction implied an ongoing relationship between Eileen and the local council, who perhaps valued the personalised relationships she forged with clients by working directly for them.

Another participant talked about evaluating personalities and characteristics of potential clients to ensure they would be suitable for their service, which were considered against the characteristics of available staff.

We do our best to match the care-giver up with the client, so it might be matching their interests, their age group, their personality – so some people might want

somebody that's quite boisterous and loud, and demonstrative. Other people want people that are quiet and calm and soothing.

Steve, CM002, community care manager

Matching workers with clients according to personal characteristics was a strong aspect of Steve's approach, and his company's, towards delivering person-centred care. Steve added it was his company's policy to plan care visits at a minimum of one hour per visit. He recalled offering a visit of 30 minutes to one client in the past, and realised his mistake when the care worker complained about the brevity of the arrangement. He added:

It's being dogged about sticking to those rules. Not everybody wants an hour's visit, and they're not the right clients for us, there are other providers that provide a different form of care let's say, that would be half an hour but it wouldn't be the same person-centred care that we provide.

Steve, CM002, community care manager

This appraisal suggested clients would need to be willing to accept the terms of engagement set out by Steve's company. By the same token, Melissa said she considered the client's behaviour and personality before agreeing to provide care.

We need to be able to know that we've got the skills here to meet their needs when they come in. So we need to know if there's anything actually about their personality or behaviour that we don't think is going to mix very well with the others, or is going to, going to take extra training or staffing or lots of little things like that, which, again, is still person-centred because if somebody does need a higher level of staff than what we've got available here, I might have to say, 'Right now, I don't think I'd be able to help you. However, let me try and recruit a couple more staff– or some - you know, some extra support, or I need to get the team trained to be able to do that particular task, then you'll be able to come in and we can support you better in that need.'

Melissa, CM006, care home manager

This extract showcased Melissa's scrupulous methods of assessment and planning, suggesting a great deal of thought went into acquiring new clients in her care home. If she did not feel able to support the person, she may have delayed acceptance to allow time for staff training or simply declined the request. These practices, like Steve's commitment to 'stick to his guns', implied refusing to provide un-personalised services was a form of person-centred care in itself. Melissa's meticulous planning may have been perceived as a basic principle of care management: ethical dilemmas might occur if a provider entered into a caring relationship and tried to end it after realising the client was unsuitable. Yet it appeared to form part of her understanding of person-centred care, as Melissa directly linked her method of behavioural care planning to person-centredness – 'which, again, is still person-centred'. Similarly, Steve explicitly referenced the term 'person-centred care' in the prior extract.

These examples have illustrated the administrative practices underpinning person-centred care management. These behaviours appeared to involve scheduling, negotiating with potential clients and other organisations, and dealing with referrals in a personalised manner. Administration was one skill developed by care professionals in the delivery of person-centred care. The full range of training and experience across the cohort is discussed in the next section.

5.4 Participants' training and experience

Professional backgrounds of participants were an important backdrop to front-line interpretations of person-centred care. Participants were asked about the qualifications and induction programmes they had completed. Of the 20 people in the cohort, 18 had qualifications in health and/or social care, as shown in Table 5.3. The participants are ranked in order of their experience, with the

most experienced at the top. Where 'Diploma' is mentioned, this refers to the Diploma programme in social care (Skills for Care, 2021b).

Table 5.3: Participants' experience working in older people's care and qualifications

Name	Role and setting	Experience with older people (years)	Qualifications and previous experience
Lucinda (CM004)	Community care manager	33	Qualified nurse. Previous experience in mental health and district nursing
Maggie (CW006)	Community care worker	30	Level 3 Diploma. Previous experience in residential care and healthcare
Charlotte (CM003)	Community care manager	25	Level 5 Diploma. Previous experience in learning disabilities and mental health
Victoria (CM005)	Residential care manager	25	Qualified nurse, level 5 Diploma. Previous experience in hospital nursing
Louise (CM007)	Residential care manager	22	Qualified nurse. Previous experience in community and hospital nursing
Melissa (CM006)	Residential care manager	20	Level 5 Diploma. Previous experience in community care
Kelly (CM001)	Residential care manager	17	Qualified nurse, specialist qualifications in oncology and elderly care. Previous experience in community and hospital nursing
Samantha (CM008)	Residential care manager	15	Qualified nurse, Master's degree in mental health. Former Care Quality Commission inspector
Nadia (CW003)	Community care worker	14	Advanced vocational certificate of education in health and social care. Previous experience in residential care
Nicola (CW010)	Community care worker	10	Level 2 Diploma
Daisy (CW012)	Community care manager & part-time worker	10	Level 3 Diploma. Previous experience as learning disability worker

Faith (CW007)	Residential care worker	10	Level 2 Diploma. Previous experience in catering for residential care
Jackie (CW002)	Community care worker	8	Level 3 Diploma. Previous experience in residential care and healthcare
Elena (CW011)	Community care worker	8	Assessor diploma in health and social care and level 3 Diploma. Previous experience as live-in carer for older people
Eileen (CW001)	Community care worker	6	Level 3 Diploma. Previous experience in residential care as caterer and care worker
Jennifer (CW004)	Community care worker	5	Training to be a social worker. Previous experience in residential care
Sarah (CW009)	Residential care worker	5	Level 2 Diploma, Care Certificate. Previous experience in community care
Steve (CM002)	Community care manager	3	No care qualifications
Matthew (CW005)	Community care worker	2	Care Certificate plus induction training through employer
Becky (CW008)	Community care worker	2	Care Certificate, studying for level 2 Diploma

The most common qualification among care workers was the social care Diploma: seven had either level 2 or level 3. Of the remaining workers, one, Becky (CW008), had completed the Care Certificate and was studying towards the level 2 Diploma. Matthew (CW005) had completed the Care Certificate; while Nadia (CW003) had completed an advanced vocational certificate of education in care and had 'probably' done the Care Certificate. Jennifer (CW004) said she had not completed any social care qualifications at the time of interview and was training to be a social worker.

Five of the nine managers were qualified nurses. One of these, Victoria (CM005), a residential care manager, held level five Diploma in addition to a nursing degree. Of the remaining managers who were not nurses, two held level five Diploma (Charlotte, CM003, and Melissa, CM006), and one, a junior manager (Daisy, CW012), had level three. Steve (CM002), a community care manager, did not have any social care qualifications.

The programmes most professionals had completed, such as the Care Certificate and Diploma in adult care, included information about person-centred care. As discussed in Section 1.4 of Chapter 1, level 2 Diploma materials explained the skills and qualities needed to understand preferences, wishes and needs of individual clients (Skills for Care, 2016a). The Care Certificate required learners to describe the importance of determining the history, preferences, wishes and needs of clients (Skills for Care, 2015). This finding suggested most workers in the cohort would have been aware of definitions of person-centred care promoted by national training guidelines. Similarly, several managers explained that many training programmes in which they had participated, either as student or tutor, had covered person-centred care. In addition, most managers (Kelly, CM001; Steve, CM002; Victoria, CM005; Melissa, CM006; and Louise, CM007) were registered with the Care Quality Commission. This meant they were directly accountable for compliance with regulations such as the Care Quality Commission's fundamental standards, which included person-centred care as a central objective. The remit of one manager, Samantha (CM008), included ensuring her employer complied with care regulations across several of its care homes. These findings suggested managers would have been familiar with national sector definitions of person-centred care.

Two participants said they had not completed any formal qualifications in health and social care (Steve, CM002, community care manager, and Jennifer, CW004, community care worker). However, both interviews reflected detailed knowledge of related principles. Steve cited his employer's internal training and policies as fundamental to his own knowledge of person-centred care, while Jennifer had studied person-centred theory during social work training.

Participants' qualifications were complemented by experience in the sector, another source of knowledge. Experience gained in professional settings can lead to vicarious learning and improvements in ability, as people acquire knowledge on the job by associating it with what they already know (Argote &

Miron-Spektor, 2011). Skills can be developed by undertaking novel tasks or tasks that have been performed repeatedly in the past, and shared knowledge becomes embedded in individual and organisational routines and cultures (ibid). This knowledge of technique can be combined with knowledge of more intangible phenomena, such as self-awareness. Professionals, especially those working in health and social care, develop self-awareness and understanding about their own and others' lived worlds with experience (Arbon, 2004). This understanding impacts on their approach to practice (ibid), and their interpretation of abstract, values-based concepts such as person-centred care.

Overall, the cohort held a formidable breadth of experience in health and social care: a combined total of 270 years, with Lucinda, at the top of Table 6.3, amassing 37 years alone². Nine of the 11 workers had at least five years' experience, as shown in Table 5.3. Other participants were less experienced, such as Eileen (a former pub landlady) and Matthew (a former information technology professional), who changed careers in their 50s and 60s respectively. The career-changers may have brought different skills and perspectives to their roles. The mean number of years' experience working with older people was 20 for residential care managers, 18 for community care managers, nine for community care workers and eight for residential care workers. One of the benefits of such a heterogeneous cohort was to enable comparison and cross-reference between beliefs and values of professionals on one hand, and individual characteristics such as role and experience on the other. It raised questions, such as whether self-employed workers would have developed different understandings of person-centred care to managers, or whether less experienced staff would have different ideas to more experienced professionals.

² Lucinda, a community care manager (CM004), had 37 years' experience in total and said around 33 of these were spent working with older people. This table focuses on experience with older people specifically, so her tally is recorded as 33 in that context.

The findings in this section 'ave demonstrated that all the participants would have been aware of person-centred care as a policy concept via their training and experience. Data in Table 5.3 suggested the strength and nature of that awareness likely varied across the cohort of participants, given the diversity in the level of qualifications and length of professional experience among the 20 interviewees. The heterogeneity of the cohort lent itself to this study of interpretations in front line care, where my intention was to capture perspectives and nuances of understanding and attitude.

Having described the context in which person-centred interpretations were developed, the second half of the chapter now considers constructions of the concept and ways in which it appeared to be manifested in practice, based on participants' own words during interviews. Firstly, person-centred care is discussed in the context of the respondents' sources of knowledge regarding the idea, and how they came to understand it.

5.5 Sources of knowledge of person-centred care

During interviews, participants were asked if anything in their personal or professional background helped them to understand person-centred care. This question featured in all interviews, enabling comparison across the whole cohort. Having analysed responses from each participant, the findings from this question were broken down into three categories: training and development, life experience, and independent study. Training and development referred to any forms of training, induction or study linked to a person's job, which was often facilitated by employers. The format of such training and development could include classroom training, online learning and studying written guidance. Life experience related to lessons learned from personal lives and family relationships. Independent study was any form of study performed under the professional's own initiative, without being required to do so by an employer.

Results are shown in the table below.

Table 5.4: Key sources of understanding of person-centred care

Key source of understanding	Number of participants	Names and reference numbers of participants
Life experience	9	Eileen CW001 (worker) Jackie CW002 (worker) Maggie CW006 (worker) Faith CW007 (worker) Becky CW008 (worker) Sarah CW009 (worker) Daisy CW012 (junior manager) Steve CM001 (manager) Louise CM007 (manager)
Training and development	8	Nadia CW003 (worker) Matthew CW005 (worker) Elena CW011 (worker) Kelly CM001 (manager) Charlotte CM003 (manager) Lucinda CM004 (manager) Victoria CM005 (manager) Melissa CM006 (manager)
Independent study	3	Jennifer CW004 (worker) Nicola CW010 (worker) Samantha CM008 (manager)

The findings in this table suggested an even split between life experience and training and development as the two most common sources of knowledge – nine participants cited the former, and eight the latter. Independent study was the smallest group. It was notable that most managers (five out of nine in total) cited training and development, which was likely to incorporate official guidance from legislation and national standards, as a key source. One member of this group, Victoria, discussed how regulation influenced person-centred planning.

It's a heavily regulated industry as I'm sure you're aware...If you, for example, have a new addition, they could be coming from different places in or out of the care sector. They might come from home, they might be coming from hospital. Or sometimes another nursing home...And then you– need to - you need to coordinate that, so you need to make sure that the pre-admission assessment is in place, which is part of what leads to them getting personalised care.

Victoria, CM005, residential care manager

Victoria expanded on the practice of formal assessments carried out for new residents.

Pre-admission assessment, very important part of person-centred care...It's actually a regulation anyway.

Victoria, CM005, residential care manager

Victoria showed strong awareness that the care sector was a 'heavily regulated industry'. She mentioned a care planning framework, a 'pre-admission assessment', which was 'actually a regulation' and an important part of person-centred care, in her opinion. The direct link between this standardised framework and person-centred care implied she framed person-centred care within the context of national policy standards.

Another manager deriving knowledge regarding person-centred care from training and development activities was Kelly. She explained:

We did some time ago, work with Dementia Care Matters for our dementia c–re. They - they used the butterfly approach...it's all fundamentally about the person. And particularly for people with dementia it's about their emotions, how their emotions influence their sort of behaviours...Yeah, it was an approach by Dementia Care Matters...But it's just about, you know, people being engaged and occupied and it being person-centred.

Kelly, CM001, residential care manager

This account suggested Kelly drew on standardised models of practice to support understanding of person-centred care. The theoretical framework here was devised by a UK-based consultancy organisation, Dementia Care Matters, which promotes a person-centred vision of dementia care in residential settings (McAlees, 2018). Kelly did not link this model to national guidance or standards, but did link it to her idea of person-centred care – ‘it’s just about...people being engaged and occupied and it being person-centred’. The line describing having done some ‘work with Dementia Care Matters for our dementia care’ suggested she utilised the ‘butterfly’ approach in an attempt to raise standards of care among her team. The depiction suggested another manager whose interpretation of person-centred care was shaped by training and development.

In contrast, workers seemed to derive knowledge regarding person-centred care from information sources outside institutional structures. Whereas most managers were influenced by training and development, which were typically offered within institutions, the majority of workers (eight out of 11) in the cohort of interviewees cited life experience or independent study as sources. This sense of disconnection from national guidance was strongest among self-employed workers. For example, Jennifer suggested there was no rulebook for people in her role:

There’s no— sort of - you know, ‘Here’s some policies and procedures about person-centred care.’ Like, that doesn’t exist in the PA [personal assistant] world. You know, you’re pretty much, you’re straight in, and, you know, you’ve got to, kind of, find your feet quite quickly.

Jennifer, CW004, community care worker

In this extract Jennifer alluded to having to ‘find your feet quite quickly’, citing an apparent lack of policies on person-centred care. This perspective implied detachment from standardised practice models, in contrast with accounts from managers such as Kelly and Victoria. The idea of going ‘straight in’ suggested a sense of isolation, away from typical development opportunities such as

learning from peers and managerial supervision. Such isolation was perhaps linked to Jennifer's self-employed status, outside the normative structures of provider organisations – for example, she did not mention regulation. The process of finding one's feet implied the development of singular interpretations of concepts such as person-centred care.

Maggie, another self-employed worker, was asked whether she had completed the Care Certificate. She replied she had not, adding:

I've been private for the last, ooh, ten years...so I don't really keep up with what's going on in the last so many years.

Maggie, CW006, community care worker

This extract indicated Maggie did not 'really keep up with what's going on' when it came to training and professional guidance, related to her status as a private or self-employed care worker. Such an acknowledgement implied Maggie's awareness of person-centred care may have come from other sources – in her case, life experience. (This point is explained in more detail in Chapter 8.)

This section has introduced varying sources of knowledge among participants regarding person-centred care. On one hand, some interviewees – particularly managers - seemed to understand person-centred care through the prism of theoretical models and standards learned during training and development. On another, some workers said they did not keep up with training and policy developments, with one saying they did not feel there was a person-centred care manual. Perhaps it was understandable that managers, among the most highly qualified members of the cohort, would be influenced by training and development. As stated in Section 5.4, most managers had qualifications and trained and supervised colleagues. It was therefore probable managerial interpretations were influenced by current policy developments, as the content of training programmes such as the Diploma would reflect latest policy guidance.

One-to-one interviews afforded opportunities for ascertaining people's views about the content and phrasing of a policy definition of person-centred care, commonly used in the sector. Responses to this part of the interviews will be discussed next.

5.6 Participant views of Care Certificate definition of person-centred care

One of the 15 standards of the Care Certificate, as stated in Chapter 1, is to work in a person-centred way (Skills for Care, 2015). To reiterate, this document said person-centred values included individuality, independence, privacy, partnership, choice, dignity, rights, and respect (ibid). One of the questions in the interview schedule asked whether participants agreed with this definition. Most interviewees endorsed the statement. For example, Louise said:

You want for them [clients] what you would want for yourself, and I would want all of that.

Louise, CM007, residential care manager

The positive tone of this answer was reflected in a response from another manager.

I think it's about focusing on people's individual needs, it's about involving them in planning and evaluating services, you know...yeah. I do, absolutely, it's all of those things.

Samantha, CM008, residential care manager

Similarly, Lucinda, who said her junior colleagues were expected to complete the Care Certificate, agreed with the definition.

*Well, I just think that's all the main things you're looking at for person-centred care.
Lucinda, CM004, community care manager*

Other participants said they supported the definition and singled out one or more specific values from the Care Certificate's list, which they felt reflected their understanding of the concept. These included dignity and respect (Becky, CW008, community care worker), independence, privacy and respect (Jennifer, CW004, community care worker), and choice (Faith, CW007, and Sarah, CW009, residential care workers). In summary, the majority of workers and managers agreed with the Care Certificate definition, although for some of the participants, specific domains seemed to resonate more strongly than others.

Two participants demonstrated ambivalence towards the statement, however. Matthew said:

*When you put it like that, that's your tick-boxy, inevitably...your sort of tick-boxy approach to delivering care...A lot of the Care Certificate is - it's all kind of really practical stuff and it has to be, moving and handling and stuff like that. It has to be: 'Here's the rules.' I think the trouble with talking about person-centred care, you can't just say: 'Here's the rule, here's the set of rules on how to treat somebody as an individual.' Because it becomes very sort of simple doesn't it.
Matthew, CW005, community care worker*

Matthew described the guidance definition of person-centred care as 'tick-boxy', implying that the Care Certificate's list of principles was a superficial attempt at describing a complex issue. His criticism appeared to relate to the simplistic style of the Care Certificate wording rather than the idea of 'treating somebody as an individual' in itself. Matthew drew a distinction between technical care standards, such as ways of assisting people with mobility problems, and more subjective, values-based topics such as person-centred care. Another self-employed worker, Maggie, was similarly ambivalent about the explanation. Her

extract begins after she was asked if she agreed with the Care Certificate's definition.

Yes, it sounds very formal, but I understand it.

Maggie, CW006, community care worker

Maggie said she understood the definition, and although claiming to understand it, the brevity of her answer implied the list of principles did not resonate with her perspective. Despite these pockets of ambivalence, the general consensus suggested the Care Certificate depiction of person-centred care was accurate. Yet there were subtle differences in perspective. While Louise and Samantha said they agreed with the whole definition, several other participants suggested one or two principles stuck out for them, with a wide spectrum of opinion as to the specific ones.

In addition to being asked for their views about the way person-centred care was defined in policy, participants were given the opportunity to explain the concept themselves. The varying perspectives identified within the data on this topic are introduced below.

5.7 How participants defined person-centred care

Data from interview transcripts were analysed for patterns within and across texts, using thematic analysis. As noted in Chapter 4, the aim of the analysis was to look for values, behaviours and practices relating to person-centred care. Special attention was paid to linguistic framing of topics and arguments within the transcripts, to try to ascertain an understanding of the topic from an emic perspective – in other words, how interviewees perceived and framed ideas within their speech (Given, 2008).

This part of the analysis focuses on prompted definitions of person-centred care – that is, answers to interview questions asking about its meaning, to seek an understanding of participants’ beliefs on the phenomenon. This analysis identified a broad spectrum of thoughts and opinions regarding person-centred care, implying person-centred practice was perceived and implemented in a few different ways. This notion of nuance was reflected in a comment by Lucinda. In an astute nod to the idea of ‘interpretive lenses’ discussed at the beginning of this chapter, the manager pointed to a heterogeneity of outlook across members of the care workforce:

As carers, as people, we’re all different ourselves, we all bring unique, different things to the care that we give. Yes, we’ve all got that same principle that we would give and deliver safe care, but – everybody has the same goal but you may go about it in a slightly different way.

Lucinda, CM004, community care manager

Just as Lucinda highlighted professionals ‘may go about it in a slightly different way’, my analysis of the themes within participant definitions of person-centred care suggested subtle differences in inclination and attitude. Three broad thematic categories of definition were identified: abstract, processual, and outcome-oriented. The following sections will describe each grouping in turn. While not drawing exhaustively on the whole dataset, these sections will substantiate the types with a selection of extracts from the interviews. It begins with the first group, abstract description.

5.8 Abstract, circular definitions of person-centred care

The first group of definitions of person-centred care was distinguished by simple descriptions. They referred to central elements of the idea as they viewed it, such as an overall objective.

It's all about the individual, really, isn't it. It's everything that they wish for their life.
Faith, CW007, residential care worker

Faith's comment suggested she fully embraced clients' views, whom she referred to as 'the individual', in her care work. She used a generalised epithet - 'It's all about the individual' - as if struggling to define an enigmatic phenomenon. Faith alluded to a grand ambition of trying to achieve 'everything that [the client wishes] for their life' through adult care. The goal was open-ended; reference to the participant's professional input was notable by its absence.

An equally strong commitment to acknowledging clients' views was shown in this extract.

Person-centred care to me means, in relation to the work I do, means keeping the client's wants and wishes at the heart of everything I do, and we do, you know the care sector. And respecting people's wishes wherever possible.
Becky, CW008, community care worker

Here, the client's 'wants and wishes' were emphatically framed as core facets of person-centred practice. There was a strength of feeling in the phrase, 'at the heart of everything I do', suggesting Becky's beliefs were strongly held. If one were being critical, this could be described as a truism, opaque and difficult to comprehend at face value. Aside from the caveat 'wherever possible' – hinting at possible barriers to delivery – Becky's stated goal was open-ended, like Faith's.

There was a similar sense of ambiguity noticeable in a definition by a manager, in answer to a question about the meaning of person-centred care.

OK, that's quite a big question. [Laughs] So, what is person-centred care, that is a very good question. And it's almost easier to think about, to actually understand it, to actually – what is the opposite of person-centred care. Which is institutionalised care...what I was saying just now. Or when you, you all get up at eight o'clock, you all eat the same thing for breakfast, and you all have lunch at the same time.
Victoria, CM005, residential care manager

Victoria seemed to hesitate at the beginning, padding her response with laughter, remarking this was a 'big question' and 'a very good question'. She described an extreme case of institutionalised care, involving people waking and dining at the same time, to illustrate the antithesis of her understanding of person-centred care. These elaborate linguistic strategies underlined the apparent complexity of the concept, suggesting a clear explanation was not easily attainable. While the imagery of an extreme institutionalised setting was emphatic, it was difficult to envisage how its opposite could be achieved.

In another extract, a participant wished to include the client's opinions in the direction of care practice; here, the presence of professional input became slightly clearer.

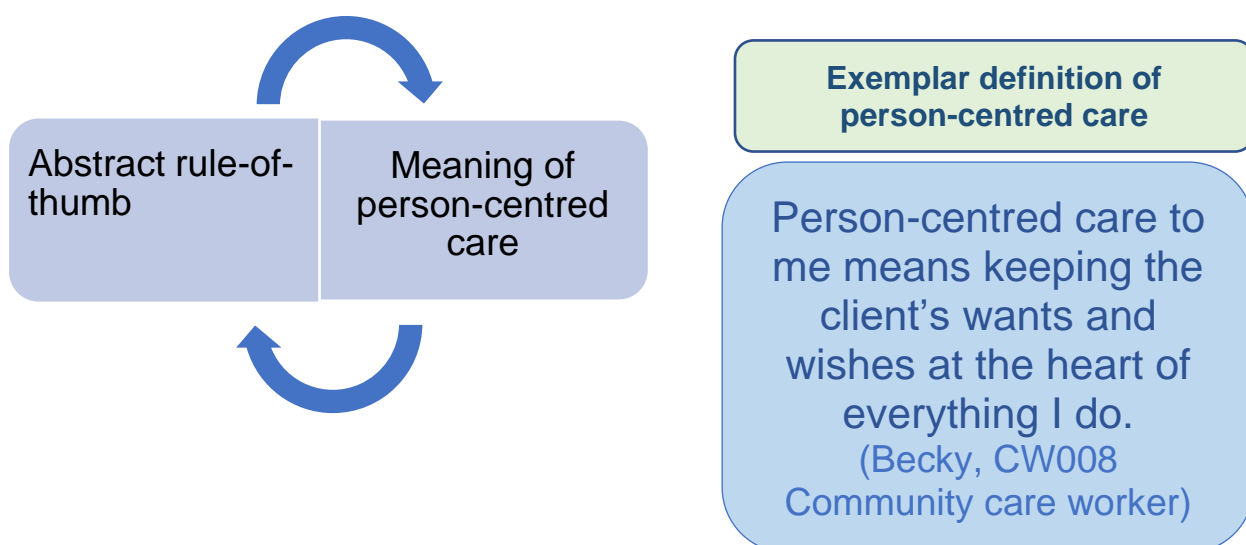
Depending on what degree of care they employ me for, it's everything, you know, and I like feeling when I've left what I've given them is what I'd like to receive myself...you know, everything. Whatever they need, and that's what I do.
Maggie, CW006, community care worker

This answer positioned the client's needs as the unarguable priority, apparent in verbal absolutes such as 'everything' and '[w]hatever they need'. Maggie referred to herself in the first person and her own activity – e.g., 'what I've given them' - on several occasions. This habit implied she had some input into imagining and achieving person-centred care. Maggie used her own interpretation of standards – 'what I'd like to receive myself' – as a yardstick of quality. Unlike the ambitious tone of Faith's commitment of realising a person's

wishes, Maggie’s definition seemed more grounded in the day-to-day context of care work. This shift was demonstrated by a reference to needs in the epithet, ‘[w]hatever they need’, as opposed to wants and wishes. Yet it remained to be seen how these needs might be supported in practical terms.

There was an abstract feel to these definitions, perceptible given the lack of practical examples in people’s explanations. Strategies were illustrated through aphorisms and yardsticks. Truisms such as ‘keeping the client’s wants and wishes at the heart of everything I do’ reminded one of the idealistic tone of policy-makers’ statements setting out the vision for person-centred care, noted in Chapter 1. (For example, as stated in Section 1.3, a government white paper (HM Government, 2012, p9) pledged to empower people ‘to choose the care and support that best enables them to meet their goals and aspirations’.) Yardsticks of practice could be a useful part of explanations. However, Maggie’s rule of thumb that she would offer the client the standard of care she would like to receive herself lacked detail, as the frame of her –reference - what she would like to receive– herself - was unclear. Such arguments could be described as one-dimensional and circular in nature, as illustrated by the diagram below.

Figure 5.1: Circular definition of person-centred care



These extracts have demonstrated the high value placed by participants on clients' views in an interpretation of person-centred care. Strategies, when discussed, were limited to relying squarely on the client's direction. Sometimes professional input seemed invisible, as in Faith's comment, which did not include any references to herself as an experienced worker. The rules of thumb, such as Becky seeking to keep client's wishes at the heart of her practice, took on the burden of explaining the complexities of the concept. As illustrated in Figure 5.1, a circular quality of the underlying argument was evident in the narrow scope of the explanation. The argument could be paraphrased thus: the professional kept the client's views at the heart of their practice to perform person-centred care, and their practice was person-centred because they kept the client's views at the heart of their practice. Other than a minor caveat raised by Becky, how those views might be reflected within care practice remained foggy and abstract. The meaning of the concept was essentially devolved to the client.

While this section has offered examples of circular definitions of the concept, other participants took a different approach to defining person-centred care by elaborating on the professional activities necessary for delivery, from their perspective. These definitions are discussed in the next section.

5.9 Processual definitions of person-centred care

The second thematic category of definitions shared an interest with the abstract/circular group, explained in the previous section, in recognising the values and wishes of the client. By contrast, though, the participants seemed to flesh out their strategies, with more detail about processes linked to capturing and implementing the client's views.

An extract from a residential care manager offered insight into activities associated with person-centred care.

As its very nature it's what it says, it's in the heart of what you do. So for us it's about getting to know the person even before they come in, so, spending as much time as you can with family and with the person.

Kelly, CM001, residential care manager

At first this statement seemed to resemble the definitions seen in Section 5.8, as Kelly's answer was embellished with an aphorism, 'in the heart of what you do'. The participant built upon this observation with detail regarding implementation - the phrase, 'for us it's about...' implying this was the chosen method for Kelly and her team. She alluded to the process of gaining knowledge of a new client prior to arrival, explaining how she would do so: by spending time with the person and their family. There were two references to 'the person' in a short passage, implying that recognising personhood was a strong feature of Kelly's practice.

An identical phrase, 'getting to know' the client, was posited by another manager:

It's about getting to know them [the resident], and what's important to them. That can be done at assessment before they even come in, or for people that have got dementia, it might be just we get to know them over time to be able to provide their care in a way that they want it or like it, or have liked it in the past.

Melissa, CM006, residential care manager

Melissa expanded upon the process of understanding not only the client's views, but also the—r values - reflected in the idea of establishing what was 'important to them'. Melissa suggested this objective might be fulfilled through formal assessment upon arrival, or, as Kelly stated, by getting to know the person generally. The repetition of this aim of getting to know the person by multiple participants suggested it was a vital distinguishing feature of person-centred care.

A detailed picture of ascertaining a client's wishes was presented by Jackie:

So, person-centred care, a lot of it is obviously common sense. You'd go in and you would check everything by that person. You know, even down to a cup of tea. You know, 'Do you have milk? Do you have sugar? Do you like this much milk, is it the right colour?' Until you get used to them, it's obviously quite hard.

Jackie, CW002, community care worker

This explanation opened with a truism, 'a lot of it is obviously common sense', hinting at an apparent difficulty in unpacking an abstract concept. A more practical example of delivering person-centred care then followed, which involved communicating with clients and understanding the person's preferences, indicated by the phrase, 'check everything by that person'. In grammatical terms, the client was the subject of the clause, depicted as the driving force of the interaction, with choices and decisions devolved to 'that person'. The care worker's telling observation, 'it's quite hard', hinted at the onerous nature of determining and acting upon the client's views, at least initially.

Another interviewee offered a processual explanation of person-centred care in more explicit terms.

So everything's around them and they get to make the decisions themselves. Which I would say I do all day long. Because— I never - I'll make suggestions and things. But it always comes down to the person and what they want to be, where they want to go, what they want to eat, or how they want things to go.

Nadia, CW003, community care worker

Here, Nadia's somewhat opaque observation, 'everything's around them', was followed by an allusion to process: '[the clients] get to make the decisions themselves'. This was a practical, logical outcome of the process described by

other participants of getting to know the person's preferences: a decision regarding care and support. This depiction of the final outcome of the process was supported by examples of decisions, such as diet, places to visit, and, in a more abstract tone, 'what they want to be'.

The strategy of building care practice entirely around clients' wishes was countered with a contrasting argument from one participant.

You might have a client, a resident that wants to do something that is really hard to achieve or not safe to achieve. So you wouldn't be able to deliver it, so if they want to go swimming in the Channel or something [laughs] that might be quite hard to achieve for most residents. But if they lived on their own, they might have a go.
Victoria, CM005, residential care manager

This comment represented an admission of possible limitations of a laissez-faire attitude towards person-centredness, in which decision-making was devolved to the client. In this case, the participant suggested a client may want to participate in an extreme sport. Victoria seemed to imply that the care professional may be unable to support them in this activity, due to apparent concerns over the person's health and safety. This was an acknowledgement that a grand vision of implementing clients' wishes to a tee could be hampered by conflicting priorities. This recognition presumably held implications for all 20 of the participants, as they were all bound by health and safety legislation.

These examples of the processes and activities linked to person-centred care have highlighted the detailed nature of some of the perspectives. In contrast to the abstract/circular style of definitions in Section 5.8, the processual definitions offered a more linear viewpoint. There was more of a narrative around processes and inputs – using communication and assessment skills to get to know the client – linked to the concept of person-centred care, which generated overall meaning.

This thematic category built upon the yardsticks and abstract truisms of the abstract/circular category and offered more coherent perspectives of the concept. Participants in the processual group, outlined in this section, attached more detailed explanations of caring interventions to the idea of person-centred care, by offering imagined conversations between themselves and a client, for example. In this model, professionals invited clients to direct care practice by eliciting their views. The participant's intervention was not fully elucidated, but more of a tacit presence in these surface-level accounts. In Nadia's observation, the client was elevated to a lofty position in the caring relationship. The care professional was positioned as an observer on the periphery, diligently awaiting signals from the client for direction of support. Yet ambiguity as to the precise task of interpreting these signals lingered. There may have been a gatekeeping role in distinguishing what was feasible and what not in regard to the client's wishes, as Victoria suggested. The task, therefore, of establishing parameters of person-centredness was not always immediately clear. The third and final group offered further insight to this complex question.

5.10 Outcome-oriented definitions of person-centred care

The final category introduced the notion of tangible objectives into definitions of person-centred care. In this explanatory model, participants defined the concept by reflecting on the outcome of their intervention.

I think person-centred care enables you to provide good quality care 'cos the person is involved in their care and you're encouraging them to be as independent as possible.

Charlotte, CM003, community care manager

Charlotte expressed a clear link between the desired outcome – encouraging the client to be independent – and the concept of person-centred care. The idea of involving the client 'in their care' appeared to be shorthand for encouraging

people to make decisions, or at least contribute to the decision-making process, about their care and support. This comment was notable for its brevity, which was unusual in answers during interviews to questions about the nature of the concept.

Another interviewee produced a highly detailed, interpretive account of person-centred care.

To me,—it means - so here's one definition that I gave for during my job interview for the second care company I worked for. And I was—asked by - I think she was very good, she was a trainer for the company, she said, when you've reached the end of the care visit she said: "How do you know whether you've done a good job or not?" I mean, without going into detail it was in essence, do I feel I've left the person in a state of happiness or calmness or reduced anxiety than at the beginning of the visit. Does the person indicate that they're looking forward to my next visit? Obviously, you know, have I got to know this person a little bit better during the visit? And last but, you know, last but not least, have I completed all of the activities or all the elements of what's in the care plan or what's in the support plan, in other words the thing that defines actually what I should be doing during the care visit. So that's one, if you like, one definition.

Matthew, CW005, community care worker

Matthew's eloquent response was lengthy: the wordiness, in itself, reflected the complexity of the topic from his perspective. There seemed a studious, reflexive quality to his approach, demonstrated by Matthew posing a series of questions aimed at his care practice. He showed attention to detail by recalling learning points from training programmes. There was evidence of critical thinking, in ranking professional objectives for caring visits in order of priority – e.g., 'last but not least, have I completed all of the activities or all the elements of what's in the care plan'. Above all, there was clear articulation of core outcomes anticipated for the client: happiness and reduced anxiety, followed by learning more about the person and developing a relationship. This account suggested

Matthew had not only clearly interpreted the concept, but had devised a coherent strategy for delivery.

In the outcome-oriented style of definition, participants displayed evidence of studious reflection in seeking to understand person-centred care through objectives relating to the client. Establishing a link between professional intervention and intended outcomes within the client produced insight into the meaning of person-centred care, from the participants' perspectives. There were fewer examples of this style of definition compared to the other categories, perhaps hinting at the complexity of this way of perceiving person-centred care.

5.11 Concluding comments

This chapter has presented findings from thematic analysis, alongside demographic characteristics of participants. A varied range of attributes in terms of age, experience, and role, implied the group comprised a strong and diverse 'community of meaning' (Yanow, 2000), offering nuanced perspectives and values that would help to answer the research question.

Analysis of prompted explanations of person-centred care, where participants were asked to define the concept themselves, were revealing. As shown in Section 5.8, some accounts were lengthy or marked by hesitation. Generalised axioms such as 'common sense', 'whatever the client needs', and 'in the heart of what you do' appeared multiple times in the data. One rule-of-thumb suggested by Maggie was that it involved giving care that she would like to receive herself. This maxim was limited because it did not offer a full description of the care style: the rule was simply stated without expanding on what kind of care she would appreciate or how that might be delivered in practice. This lack of clarity should not be taken as a criticism of participants. Indeed, such opacity points towards a common notion in qualitative methodology, that meanings were often known tacitly, not explicitly (Yanow, 2000). Furthermore, local actors

were often ambivalent about some of the complex national policies they are asked to implement, in which ambiguity was sometimes a feature (West, 2012).

Some participants elaborated on those abstract descriptions of person-centred care by linking process to their understanding of the concept. For example, getting to know the client as a person and 'checking everything' by them appeared important features of person-centred approaches for some workers and managers. These accounts implied a linear relationship between interpretation and practice: 'I understand *x* by doing *y*'. This explanatory model had potentially more heuristic value than the abstract/circular arguments seen in Section 5.8. Analysis of *in vivo* accounts of outcomes mentioned during interviews with some participants suggested increased happiness and independence were central objectives. I interpreted these as outcomes intended for the old-r person - as Matthew said, he attempted to leave clients in a state of happiness or reduced anxiety when he signed off visits. These constructions of the idea added eidetic value to conceptual interpretations. The detailed checklist of questions Matthew asked himself during each visit was a powerful example of an in-depth reflexivity within his understanding of person-centred care.

I wanted to build on these initial findings of surface-level depictions, based on prompted explanations. This would involve examining the panoply of beliefs, values, and practices linked to person-centred care among the cohort. The tacit nature of these meanings meant deeper analysis was required. At this point, framework analysis was used to take a cross-sectional view of data. It enabled close study of relationships between themes, practices, and participant characteristics, to reveal distinctive ways of understanding and enacting person-centred care. The findings of this analysis are discussed next.

Chapter 6: **Introducing three-part typology & first group, Nurturing Mental Health**

6.1 Introduction

The following three chapters are based on the findings of framework analysis.

This

incorporated some of the themes attached to conceptual meanings during thematic analysis, and led to the construction of a three-part typology. This typology illustrates a spectrum of beliefs, values and practices relating to person-centred care, extrapolated from interviews.

The devising of the typology is explained in the first section of this chapter. The remainder is dedicated to describing the first group within the typology, Nurturing Mental Health, and its members' interpretations of person-centred care. The members and key elements of the model are introduced, followed by a pen-picture introducing one participant. Subsequent sections offer accounts of core elements for Nurturing Mental Health: i) psychological assessment, ii) facilitating activities, iii) happiness. An additional findings section describes the role of performance in members' care practice. The chapter concludes with discussion of member participants' most prominent sources of knowledge of person-centred care.

6.2 Formulation of three-part typology

Surface-level depictions of person-centred care, derived from thematic analysis of the interview data and discussed at the end of Chapter 5, hinted at some of

the local reasoning (Bevir & Rhodes, 2016) behind participants' interpretations. In an actor-centred approach to empirical inquiry guided by interpretive policy analysis, it was important to identify underlying values and beliefs, which would, in turn, shape practices (ibid). Such reasoning would connote a framing of the policy issue by local informants, based on expert knowledge and lived experience, offering meaning to the phenomenon in question (Yanow, 2000, p4). As mentioned in Section 4.8 of Chapter 4, framework analysis was employed after coding the whole dataset. Matrices involving key thematic categories and participants were developed in Microsoft word and NVivo, to map patterns of values, beliefs, and practices. One of the main findings of Chapter 5's thematic analysis was that processes and outcomes appeared to be key to understanding the complexities of person-centred care. I tried to develop this finding by cross-referencing codes relating to participant practices, and values-themed codes relating to outcomes such as happiness, independence, and so on. I recorded findings from this cross-referencing, showing prevalence of references for each participant according to different themes.

These initial findings led to the development of the typology. The overarching structure included higher-order themes grouped around three stages of practice linked to person-centred care. In a logical order that care professionals might follow, these were: the identification of personhood ('Seeing the Person'); the nurturing or stimulating of personhood ('Stimulating Personhood'); and the outcomes, or positive changes seen within the client as a result of person-centred care – what I have called 'Expressions of Personhood'. These three stages were developed into structural themes, which underpinned the typology as a whole.

<i>1. Seeing the Person</i>
<i>2. Stimulating Personhood</i>
<i>3. Expressions of Personhood</i>

Figure 6.1: Structural themes underpinning the typology

I developed the typology by populating the third category, Expressions of Personhood, with desired outcomes participants appeared to talk about in relation to their clients. The three defining outcomes were happiness, intimacy, and agency, which were linked to good practice from the perspective of participants sharing each viewpoint. The typology was expanded to include other high-order themes relating to Seeing the Person – practices grouped around identifying preferences or establishing a connection - and Stimulating Personhood – practices relating to engaging with the person. I explored the weight and prevalence of these themes among different participants on a transcript-by-transcript basis. I used crosstab queries in NVivo to identify the numerical spread of selected codes across the data. Results on the frequency of occurrences of specific themes within individual transcripts were produced. After transcript-by-transcript analysis I cross-referenced individual transcripts against themes grouped under elements of the typology. Participants were allocated to one of three distinct groups according to their beliefs, values and practices, reflected in the frequency of occurrences of specific codes in individual transcripts. This was an example of a single-linkage typology, in which identification with a set of positions on one dimension was systematically aligned with a set of positions on another dimension (Ritchie et al., 2014, p325).

The allocation of participants to a typological group depended on the weight of occurrences of themes in their transcripts. Each typological group had three core facets, grouped under the stages-of-practice themes mentioned above. These are presented in the table below.

Table 6.1: Dimensions of typology alongside the stages-of-practice model

Typological group	Dimensions of group		
	Structural theme 1: Seeing the Person	Structural theme 2: Stimulating Personhood	Structural theme 3: Expressions of Personhood

Nurturing Agency	Assessing a person's strengths	Facilitating decision-making	Empowerment
Nurturing Mental Health	Psychological assessment	Facilitating activities	Happiness
Nurturing Intimacy	Gaining consent to provide care	Phatic engagement	Intimate caring relationship

Analysis of distribution of codes in relation to these three structural categories – Seeing the Person, Stimulating Personhood, and Expressions of Personhood - facilitated allocation of participants to an appropriate typological group. A participant expressing strong beliefs, in terms of the number of codes identified in their transcript, for specific typological bands was allocated to that group as a member. An example of this is shown in the table below, for a randomly chosen participant.

Table 6.2: Example of key thematic code distribution relating to a single participant

Participant: Steve (CM002), community care manager	
Thematic code (typology group)	Number of occurrences in transcript
Facilitating consent (Intimacy)	5
Phatic engagement (Intimacy)	5
Intimate caring relationship (Intimacy)	6
Assessing strengths (Agency)	0
Facilitating decision-making (Agency)	1
Empowerment (Agency)	2
Psychological assessment (Mental Health)	0
Facilitating activities (Mental Health)	1
Happiness (Mental Health)	0

This table shows correlation between thematic codes within Steve's transcript and Intimacy dimensions. This is because the highest number of occurrences of themes for this participant fall within the Intimacy group. Therefore, Steve was

allocated to the Intimacy group. The process was repeated for each participant. The spread of coding occurrences across the whole dataset is illustrated in the graph below.

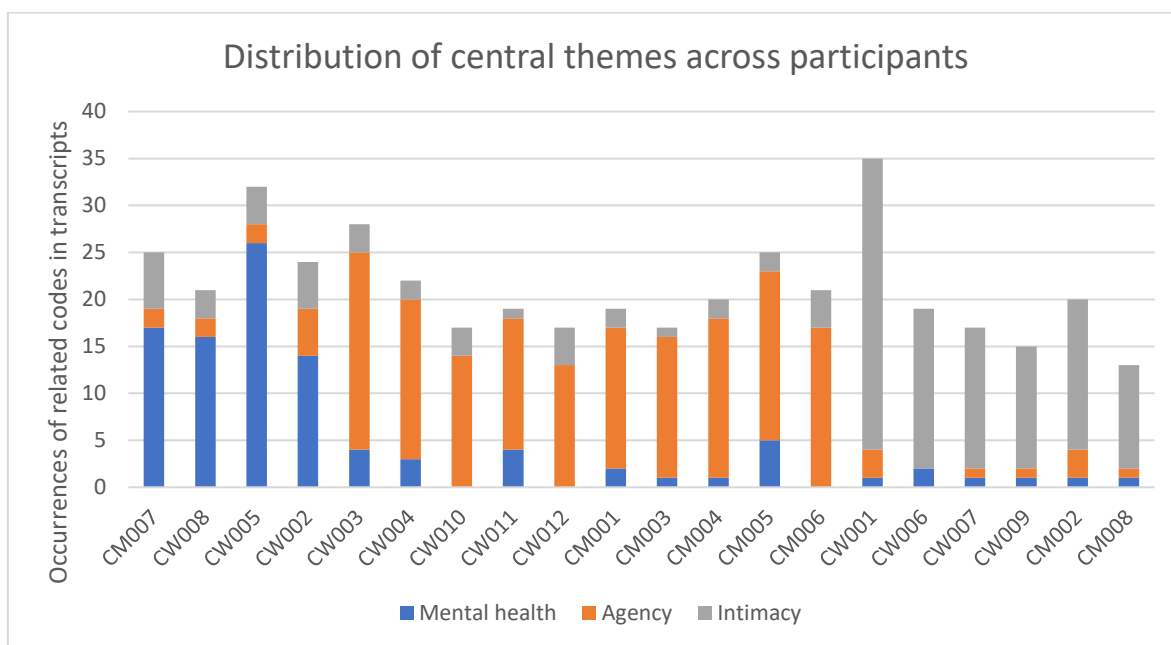


Figure 6.2: Distribution of typological themes across participants

This graph shows the intersections of relevant codes within the typological dimensions and their spread across the three groups, Nurturing Mental Health, Nurturing Agency, and Nurturing Intimacy. Each participant is represented by a column on the chart, with the participant number labelled at the bottom of each column. The presence of thematic codes in each participant’s transcript is represented by a different colour: blue for mental health, orange for agency, and grey for intimacy. The presence of other colours within a group or participant shows a small amount of thematic overlap, in which participants expressed beliefs or behaviour associated with a different group. For example, some of Steve’s comments pertained to empowering clients. However, there were three times more occurrences of codes relating to intimate caring relationships; such clear prevalence meant this participant was allocated to the Intimacy group.

Developing the typology was an iterative process: findings presented here are the final constructs of the model, but the typological categories were revised numerous times as the analysis progressed, in order to ensure they clearly captured intersections between different dimensions (Ritchie et al., 2014, p328).

In this chapter and the subsequent two chapters, the three typological groups are presented in broadly the same format. This includes an introduction to the members and key components of the person-centred approach, followed by a pen-picture based on interview data from one of the group members, which I felt would help illustrate the key themes of the perspectives through first-person testimonies (as discussed in Section 4.7 of Chapter 4). The descriptions contain a pen-picture linked to only one person per group, with participants selected because their interviews offered coherent narratives distilling core themes of the relevant typological category. The remainder of each group description includes discussion of the members' engagement with different aspects of personhood, including seeing, stimulating, and nurturing the person's strengths and qualities.

The first typological group, Nurturing Mental Health, is introduced below.

6.3 Introducing Nurturing Mental Health: typological group

I've never seen such happiness in another human being.

Matthew, CW005, community care worker

The first group within the typology was Nurturing Mental Health. Members of this group were interested in the emotional aspects of care work with older people. Their expertise relied on observation and interpersonal skills to tune into a person's psychological wavelength, deploying natural charisma, and adjusting one's demeanour to suit the client's temperament. Creative planning skills were used to facilitate stimulating activities and long-cherished hobbies – or perhaps

introduce new ones – with an overarching aim of lifting the mood of clients. Nurturing Mental Health assumed that older people deserved to be happy, and this outcome would improve their well-being. The quotation from Matthew (one of the member participants), above, reflected this philosophy. The remark encapsulated one of the group priorities: maintaining the mental health of older people.

6.4 Overview of Nurturing Mental Health

The four members of the group are as follows:

Table 6.3: Members of Nurturing Mental Health

Participant number	Participant	Job status	Setting
CW002	Jackie	Self-employed care worker	Community
CW005	Matthew	Self-employed care worker	Community
CW008	Becky	Provider-employed care worker	Community
CM007	Louise	Provider-employed manager	Residential

The numbers were small, therefore it was difficult to draw conclusions about the membership and their characteristics. However, three out of four members were community care workers, suggesting that the client's home, away from

potentially restrictive rules of a care home, might be conducive to a more creative approach. This argument was substantiated by a remark from Jackie:

As far as person-centred care goes, it's obviously a lot better in somebody's house, 'cos, you know, everything's to their liking anyway.

Jackie, CW002, community care worker

Jackie had previously worked in care homes and hospitals but preferred working in community settings because she felt it was more suited to person-centred care.

The key components of Nurturing Mental Health practice are represented in the diagram below.

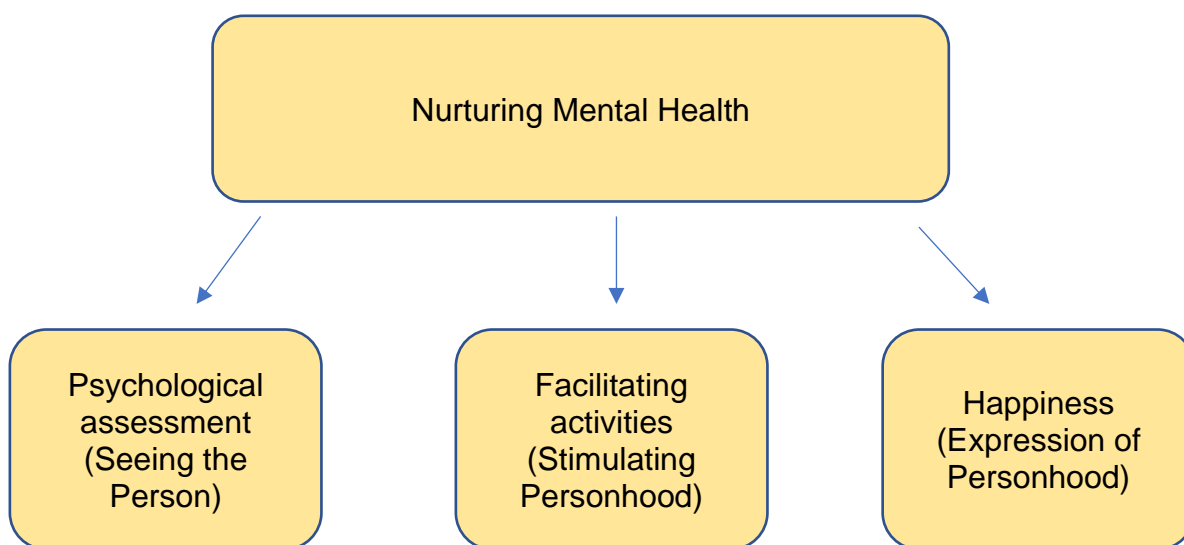


Figure 6.3: Key components of Nurturing Mental Health perspective on person-centred care

Some of the key discussion points relating to Nurturing Mental Health are reflected in Matthew's pen-picture, below.

6.5 Pen picture introducing a Nurturing Mental Health member

The following pen-picture is an introductory narrative describing one of the member participants of Nurturing Mental Health. It is a collation of extracts from Matthew's interview transcript, some of which have been edited for clarity.

Matthew, 63, self-employed community care worker, South West

"I was a late starter to the care sector. I worked for many years in the IT [information technology] industry and in my late fifties I left to become a carer. I started working for a couple of care companies and six months ago became self-employed. My current job title is personal assistant. I provide services that are mostly around-enabling - allowing and helping service users to have some level of social contact and to engage in the community, going out to have a coffee and so on.

As I got into it I just developed my own way of thinking, so I absolutely wanted to put the person, the individual, we say, at the heart of what you're doing. When I think of delivering person-centred care in my visits I am thinking in terms of what are this person's needs, what are their social needs? So that I leave them in a state of happiness and serenity and they feel that they've been stimulated in some way.

What you're trying to do is you have to do the basics, but the really interesting thing, the thing that makes it a really interesting job, is getting to know them, making them feel like they want to see you again, you know, knowing them more and more each time you visit. And it – this does sound really woolly, and, you know, I'm not a religious person but kind of connecting with their spirit.

Because from a care point of view, you're doing enormous benefit to their mental health in ways that aren't measured and aren't in the care plan. And it was that bit that I really enjoyed.

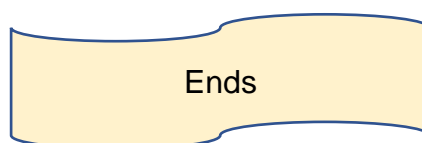
It is a constant intellectual challenge to think of ways of enriching the person's life beyond delivering care. I have a lot more time doing these enabling visits so it can be a really, really interesting job if you want it to be.

I enjoy working with older people. By and large anybody would enjoy working with somebody who is polite, pleasant, appreciative, thoughtful, and that's what I see with older people. When I'm working with people who have dementia there are multiple communication and interaction challenges to be able to connect with them, in order to be able to meet my objectives of making them feel relaxed, happy and stimulated. I find when I'm successful I enjoy it. Lots of people say, 'It's very rewarding.' But actually it's very hard. Don't underestimate the depressive effect of spending a lot of your waking hours in the presence of people who've got dementia. It's quite hard.

People take a very risk-averse view to delivering care. One example is a man in his eighties, with dementia. He has a big, ancient lawnmower and wanted to mow the lawn. My colleagues at the time didn't want to allow it because of the risk to his safety and we ended up having a row about it. In the end I let the guy mow the lawn and supervised him while doing it. That was an example for me of delivering person-centred care, because afterwards he felt uplifted and happy and he was relaxed. If you're looking at the risk, well, what's the risk to a person's mental health if they feel they're in a care prison? Completely protected from any physical risk. The support is imprisoning them and stopping them from doing what they want because the carer says it's not safe. And that's how I try and think about it.

When I was working in IT I was in a well-paid, senior job. It was just making sensible decisions, reading people and understanding, but in terms of the

intellectual challenge it was nothing compared to what I'm doing now. Which I find absolutely extraordinary. I'm 63 now and although it's not very well-paid, I plan to do this for as long as I can. Because I enjoy it very much indeed."



Reflections on Matthew's pen picture

Matthew's interview was chosen for this section because his attitudes towards person-centred care appeared strongly aligned with core ideas of Nurturing Mental Health. This participant showed a keen interest in the psychological aspects of care work with older people, inferred by references to intellect and feelings in the pen-picture. Matthew commented on there being 'a constant intellectual challenge to think of ways of enriching the person's life beyond delivering care'. This expression of achieving something 'beyond delivering care', was telling, hinting at a spiritual dimension to the role. He talked about helping clients to feel relaxed and stimulated, believing this would do 'enormous benefit to their mental health', regarding the impact of his care practice on clients. He said he tried to connect with a person's spirit, encouraging 'a state of happiness and serenity and they feel that they've been stimulated in some way'. Interestingly, Matthew felt these outcomes were not typically captured within a care plan. This observation implied Matthew enjoyed the freedom to practise creatively, as a self-employed worker, outside the conventional care system dominated by provider companies.

The recognition that person-centred care might be defined through outcomes was an important finding, as originally suggested in Section 5.10 of Chapter 5. In this case, Matthew explicitly articulated the objectives of his interpretation of person-centred care, of increasing happiness and serenity within the person he

was supporting. This was substantiated by his anecdote involving an older person mowing the lawn. Matthew's telling of this narrative implied a sense of satisfaction at witnessing the client's mood lift as a direct result of the care practice. A clear link was expressed between the client feeling happy, uplifted, and relaxed and the delivery of person-centred care, from Matthew's perspective. Allowing the client to enjoy a favourite hobby, conducted on the client's terms, represented a successful Stimulation of Personhood from Matthew's perspective.

For Matthew, the most enjoyable and challenging facets of the job related to psychological issues. Nurturing Mental Health could be a double-edged sword, however. The participant enjoyed his work 'when I'm successful' but saw his job as an 'intellectual challenge', admitting one of the pitfalls was possible mental exhaustion. (Matthew hinted he had experienced this while struggling to engage with people with dementia.) The reflective tone of Matthew's comments and references to these topics implied he perceived the idea of well-being through the prism of the psyche: his own, and that of the person he was supporting.

6.6 Seeing the Person: psychological assessment

In order to facilitate person-centred care through the prism of the psyche, the first step was to see the person by understanding their emotional and behavioural traits. A practice of observing a client's state of mind represented a key activity for Nurturing Mental Health members: psychological assessment.

Data suggested there was an emphasis on close psychological observation of the client, as projected by the language in this example from Matthew.

–If you are - if you are thinking about putting the person at the centre of the service that you are providing then you need to know and get to know that person actually quite quickly, and understand their expressions, emotionals, their mental state, their

emotional state, you know, the problems that they've got, et cetera.

Matthew, CW005, community care worker

Matthew's concern with 'expressions, emotionals...mental state, their emotional state', implied close observation of the client's expressions and emotions was a key part of day-to-day practice. The reference to time – having to understand all of this 'quite quickly' – implied some of the practical constraints of the job, relating to schedules. It was noteworthy that Matthew made a direct, explicit link between the concept of person-centred care – 'if you are thinking about putting the person at the centre of the service' - and the process of understanding the person emotionally. This observation solidified the relevance of psychological assessment to an overall interpretation of person-centred care.

Another example from Matthew related to a wider discussion about how he might approach a first visit to Linda, a fictional client from the vignette.

I will do everything I can to make her feel that I'm very pleased to see her, but again that has to be judging around her personality and her energy. So if she's a shy person, she doesn't want me in her face. If she's an extrovert she might, you know, might use kind of cheeky – some of these old women, they're pretty cheeky! So encourage that, and, and sort of have a bit of an interplay.

Matthew, CW005, community care worker

The interactions described here appeared to have two stages. Firstly, a telling phrase, 'judging around her personality and her energy', was a strong illustration of psychological assessment, inferring a process of reading the room. Secondly, Matthew adjusted his behaviour according to this initial assessment. References to a 'cheeky' sense of humour and having 'a bit of an interplay' indicated the participant's use of natural charisma and adoption of a persona to stimulate interpersonal engagement.

Jackie displayed heightened awareness of behaviour during discussion of person-centred care skills.

Listening, that's another one. Body language, you can go in and you can sense when someone's anxious...A-d it's all - it's all down to asking questions and body language. You're sensing when they're getting aggravated, especially with dementia, it gets harder again. I don't know how to explain it. 'Cos I remember a lady who had three hours' enablement time to give her husband a break. And it's like, she would either want to sit there in silence, which makes you feel a bit strange to start with an- you think - you keep trying to talk to her and it's making her feel awkward. She just likes you being there. And that's fine.

Jackie, CW002, community care worker

The phrase 'I don't know how to explain it' implied a sense of difficulty Jackie felt in explaining her expertise. However, an artful, intuitive approach apparent in the extract belied this self-deprecation. This anecdote suggests she came to learn one of her clients preferred to sit in silence during care visits, as she observed attempts at conversation were likely to make 'her feel awkward'. It was not clear whether the client had explicitly asked Jackie to sit with her in silence. Perhaps it became implicitly understood as visits unfolded. Jackie's point that 'it's all down to asking questions' suggested talking was important, but there was an acknowledgement of the limitations of verbal communication. The extract included several instances of attempting to identify tacit messages, noticeable in the comments, 'you can sense when someone's anxious', and 'body language'. Such heightened awareness of people's emotions and behaviour perhaps allowed Jackie to tap into people's unspoken preferences more clearly.

The practices of Nurturing Mental Health involved reading, or attempting to read, a person's psychological and behavioural traits to support emotional engagement. Jackie suggested this process was not always straightforward.

'Cos when you first go into meet someone, and I try, you know, you're trying to do a care plan the best you can without knowing them. At the beginning you think, you say, 'What sort of things do you like,' and they go, 'Oh, I like listening to music'. And you think to yourself, 'Right, well I'm going to try and make a point of asking them'. And: 'Do you want to sit and listen to your music today? Do you want to do that?' And then as time goes on you actually realise that they don't listen to music a lot, and that was probably the wrong question to ask.

Jackie, CW002, community care worker

This imagined exchange hinted at challenges surrounding psychological assessment and verbal communication. Jackie's account implied some potential missteps: clients might respond to questions out of politeness, without necessarily being accurate. By persevering, reflecting, and attempting to see a deeper version of the person, going beyond superficial levels of small talk, Jackie demonstrated expertise linked to core principles of Nurturing Mental Health.

Similarly, Louise talked about observing the psyche of residents in her managerial role.

You need to read their language, because you then need to get to the root, if they're happy, you continue the happiness. If they're upset, you need to reduce it.

Louise, CM007, residential care manager

Observations such as 'reading' a person's language and emotional state implied finely tuned skills of perception. Getting 'to the root' was a striking phrase, implying that, like Jackie, she attempted to probe beneath surface-level presentations and gain a deeper understanding of personality. The explicit reference to happiness was a neat substantiation of the model's overall objective, to nurture a person's mental health. Louise developed this theme with discussion of communication, adopting an introspective angle.

So obviously it's how you communicate, so, your use of language, your use of phrases, your use of body language and verbal. So it's about how you're presenting what you might be trying to offer them, or encouraging them to do. So you need to get to know the person and what might upset them.

Louise, CM007, residential care manager

In this extract, Louise turned her focus on care professionals' behaviour and the impact it might have on clients. This observation linked to Matthew's point about understanding the 'emotionals' of a person: Louise sought to interpret a person's mood and possible emotional triggers to inform subsequent practice.

Another anecdote from Louise reflected an interest in encouraging psychological assessment among her staff.

We've got a new member of staff who's quite loud. I've asked her to calm-down a little - shall we say, little bit over-exuberant. And: 'Well, I'm just trying to make them happy!' I said, 'I know, but you're actually irritating a few. So let's bring that back in.' And I said, 'Because one of my ladies is now seeing you and walking away. You're just in her face a bit too much, too gushy. And they can't take on a full conversation. You need to pause and you're not.'

Louise, CM007, residential care manager

Here, the colleague's intention was to increase people's happiness, evidenced in the reported comment, 'Well, I'm just trying to make them happy!' However, not only was this effort unsuccessful, it had the effect of 'irritating a few', according to Louise. Her advice to 'bring that back in' was another inference to reflexively regarding one's own behaviour, and the impact it would have on clients.

The theme of psychological assessment was neatly summarised by Becky, who commented:

I can only speak for– myself but I - I tend to generally dislike talking about myself but I love hearing about others and how they're feeling and I feel really in tune into how someone is feeling.

Becky, CW008, community care worker

Becky's desire to 'feel really in tune into how someone is feeling' vividly reflected the practice of assessing a person's psyche. This action was fundamental to an understanding of person-centred care shaped around Nurturing Mental Health. The findings of these psychological evaluations could inform the next stage of practice: facilitating activities.

6.7 Stimulating Personhood: facilitating activities

Proponents of Nurturing Mental Health embraced activities as a way of stimulating happiness and relaxation among their clients. Section 6.5 included an example of an older person who wished to continue gardening. The client had chosen the hobby, and the professional (Matthew) tried to facilitate it. Another example of client-driven activities was described by Becky, who helped to indulge a person's love of music.

The lady I support in the– evenings, we - she loves John Denver and Rod Stewart so we blast that out, we're dancing and we're singing to it.

Becky, CW008, community care worker

This scenario seemed to differ slightly from Matthew's supervisory role, as Becky described joining in with the dancing and singing herself (signified by the first-person plural pronoun, 'we'). The casual, upbeat tone of phrases such as 'we blast that out' implied a sense of personal enjoyment by Becky.

In other accounts the professional would proactively suggest a new hobby for a client. As Matthew explained:

What do you do with somebody who's got dementia? So I taught somebody with dementia to fly a kite. Now he can't do very much, he's got very, very poor spatial awareness, but I thought, 'Can you, you know, can you cope with just holding onto the string, basically, flying a kite.' And I've never seen such happiness in another human being. So, you know. Teaching somebody to fly a kite, I think it's thinking all the time, about what can this person do? What can I actually help this person do?
Matthew, CW005, community care worker

Matthew appeared to have diligently selected the activity of kite-flying, taking the person's 'poor spatial awareness' into account. The diligence was projected by the practice of 'thinking all the time, about what can this person do?' Multiple references to teaching – 'I taught somebody...to fly a kite' and 'Teaching somebody to fly a kite' – suggested he may have had a significant role in supervising and demonstrating. The result was the client experienced pure happiness, according to Matthew.

Other interviewees shared Matthew's practice of painstaking, creative planning of activities. As Louise explained:

And so it's finding them their activities, that they like. Who likes to go for a walk. We've got a dog here, he's my dog. And we've got a couple of people here that absolutely love the dog. You can get them outside and go for a walk then...So it's tapping into things that would have made them happy prior to the confusion of dementia.
Louise, CM007, residential care manager

It appeared Louise skilfully organised resources in her care home to plan stimulating activities for her residents. She recalled bringing a pet dog from home for residents and organising outdoor walks. The phrase 'tapping into things' was an interesting choice of vocabulary, having a therapeutic, investigative feel to it. (It was similar to the idea of 'reading' or 'getting to the root' of a person, discussed in Section 6.6.) This goal was especially relevant

when working with people with cognitive impairment, which could make communication and self-expression more challenging – projected by the remark, ‘prior to the confusion of dementia’. The objective, Louise said, was to inform activities that would have made the residents happy prior to dementia. This explicitly substantiated the core objective of Nurturing Mental Health, increasing happiness.

Elsewhere, Louise described bringing a sewing machine to make curtains for a communal area of the home. One resident showed particular interest.

This fantastic thing I did a few months ago, and it still makes me smile, is the fact that I brought my own sewing machine in, brought some material in and we made curtains. And I chose the lady that I was going to do it with who I knew made all her own bedding, son's clothing, tablecloths, you know, everyone had a tablecloth going back...And off she went. And she had no dementia for the whole of that time. She was completely focused on something that was of interest to her that her muscle-memory showed that it was still there. And she was feeding the material in, she operated the foot-pedal without even knowing she was doing it. ...But we - she was so pleased when she went and hung it up with me. It was one of my happiest moments, I won't forget it.

Louise, CM007, residential care manager

In this account, Louise appeared to be brimming with warmth and enthusiasm at recalling how the resident enjoyed rekindling an old passion. This was visible in the description, ‘she operated the foot-pedal without even knowing she was doing it’. There was a sense of mutual accomplishment, suggested by the line, ‘she was so pleased when she went and hung it up with me’. The outcome was remarkable, according to Louise: ‘And she had no dementia for the whole of that time.’ The fondness embedded within her telling of the anecdote suggested she had successfully tapped into the person’s psychological wavelength, for the duration of this activity.

The accounts in this section had a positive outcome, but this was not always the case, as Jackie discussed in relation to one of her clients.

And I try, every week I come in and I still say: 'Shall we go out this week? Shall we go out?' And she's like: 'I'll let you know later.' And I come in and I'm like: 'Right, did you want to go out, 'cos I'll leave the car in the drive.' And she'll be like: 'Oh, no, 'cos it might rain later. And also 'cos of this.'...Otherwise— we sit and I - you know, sometimes, she's another one, she just wants to sit and watch the telly but she knows I'm there.

Jackie, CW002, community care worker

Evidence from this extract suggested participation in activities would sometimes only be done on the client's terms. In this case the client was in her eighties and often expressed reasons for not wishing to go out but this did not stop Jackie from trying: she explained 'every week I come in' and continued to suggest excursions together. They seemed to find middle ground with the lady choosing to stay in and watch television with Jackie nearby.

Another example shared by Jackie showed facilitation of indoor hobbies could be just as rewarding as outdoor activities. This related to one of Jackie's former clients with stroke-related paralysis.

She could literally only blink. And I used to sit and read to her. A—d it was like - I'd go through every single book and she, she would blink. She would blink for yes, and she wouldn't blink for no, sort of thing. So sometimes I'd go through all of her books before she would blink. Whereas some people might just come in and grab a book off a shelf and go, 'Oh, shall we carry on with this and do this.' Whereas I would, sort of, wait and see, you know, and just, 'Do you want to read this one again? Do you want to do that?' You know, you might have read it before, but she still might want to read it again.

Jackie, CW002, community care worker

In this example the choice of literature was left to the client; Jackie helped select an appropriate book and recited from it, thus giving something of herself to the process.

The material in this section has substantiated the theme of facilitating activities as a common thread running through the interviews of Nurturing Mental Health practitioners. Whether the idea was pitched by the care professional or the client, the workers and managers facilitated some recreational activity designed to stimulate the person's mental health. The combined practices of psychological assessment and facilitated activities led to the final stage of practice: the desired outcome of increased happiness, discussed below.

6.8 Expressions of Personhood: happiness

The desired outcome of Nurturing Mental Health was to increase the client's happiness. All group members mentioned the words 'happiness' or 'happy' when discussing objectives for the people they were supporting. One of the most articulate accounts relating to outcomes by a Mental Health group member came from Louise, who described her philosophy as follows:

It's finding out about that person and then knowing how that person operates. It's knowing their likes and dislikes, what bothers them, what makes them happy, how can we make them maintain their happiness and increase their happiness?

Louise, CM007, residential care manager

This explication neatly tied off other strands of person-centred care practice discussed by Louise. Judging by extracts from Sections 6.6 and 6.7, she read the person's behaviour and emotional triggers, and planned appropriate activities. The objective, confirmed explicitly in this passage, was to help the person maintain or increase happiness. Louise had already hinted at one of her clients experiencing this mental benefit after one of the successful activities –

the resident who was 'so pleased' by the act of sewing, discussed in Section 6.7.

Another example detailing this outcome was from Matthew, which builds on a theme originally introduced in his pen picture (Section 6.5).

Well, one example is I let the guy mow the lawn. So that was an example for me of delivering person-centred care. Because when he finished mowing the lawn he felt uplifted and he was happy and he was relaxed, and this person's living with dementia.

Matthew, CW005, community care worker

Matthew's perception of the suitability of gardening as a client activity was reinforced when he noticed the man feeling 'uplifted and he was happy and he was relaxed'. Those benefits to his mental health implied the facilitation of this activity was an example of person-centred care from a Nurturing Mental Health outlook.

In addition to Becky's musical repertoire, she organised excursions to local beauty spots for clients. She talked about taking one older man, a retired professor, to a cherished garden, which had been the venue of his retirement party several years previously. When asked how the person felt afterwards, Becky said:

I hope that he felt emotionally nourished. I hope that he felt very happy. At the moment I only spend two hours with him a week, so that's quite limited, but the difference that I see in him when we do go out is just amazing. And he will come back and he will have a smile on his face and he would usually struggle with his speech, and you know, he manages to talk beautifully and really coherently. And I think that's probably from feeling very happy, so that's how I tend to take it anyway, or I hope so at least.

Becky, CW008, community care worker

Becky explicitly mentioned the hope that the client felt 'very happy', while expressing satisfaction at seeing 'a smile on his face' and improvements to the client's speaking ability. This was apparently in no small part due to Becky's skill

in organising tailored sightseeing visits. The participant concluded her answer with caveats of 'I hope that he felt...' and 'that's how I tend to take it anyway'. These reinforced the idea that impressions of people's outcomes were naturally subjective.

These examples have illustrated participants explicitly discussing ideas around making clients happy or being concerned with their happiness, and linking those outcomes with the idea of good practice. This perception reinforced the existence of happiness as a central objective of the Nurturing Mental Health group's vision of person-centred care. In addition to expertise in psychologically assessing people and facilitating activities, Nurturing Mental Health members utilised personal attributes, such as charisma and performance skills. These qualities are discussed in the next section.

6.9 Performing a role within Nurturing Mental Health

Nurturing Mental Health members talked about projecting a persona during interactions with clients – such examples were identified in interviews with Louise, Matthew, and Jackie. Louise, a care home manager, sometimes cast herself in the role of flamboyant performer, playfully addressing an audience of residents in communal areas of the residential home. Her interview was conducted in December as the home was preparing for Christmas. Louise had dressed appropriately, as she said she was wearing a Christmas-themed hairband that day.

You know, it's all part of Christmas, we're dressing up, Christmas jumper day today. So a lot of it is laughing at myself, I might go in and dance, do things like that. And I might say, 'Anybody want to dance with me? OK, you don't want to dance with me then.' You know, you can have a bit of a laugh, but you can't do it with everybody...but a couple of them you can have an absolute giggle with, at certain

times of the day.

Louise, CM007, residential care manager

This extrovert performance, in which Louise tried to get people into the Christmas spirit, was an opportunity for the manager and residents to share laughs and relax together. Louise's reference to 'laughing at myself' pointed to a self-deprecating sense of humour. There were caveats, however: her performance may not be appropriate for some people – 'you can't do it with everybody' – and should only be done 'at certain times of the day'. These disclaimers suggested Louise applied psychological observation skills when choosing to perform.

Jackie and Matthew, both community care workers, appeared to study the social milieu of client and surroundings before determining an appropriate demeanour to adopt.

I think just being calm in general in yourself, if you're a flappy, panicky person that's going to put someone right off...like I said, you go in, you're flapping because you're late. Because you're late from the last one 'cos you got no travel time. And so you're panicking, you're flapping, you've walked into someone's nice calm house, and then they can see your body language, and, you know. Yeah, that'll put them right off already. They don't know you, and then you've come in already, I don't know, like, with the adrenaline going, I think you've got to be calm as well.

Jackie, CW002, community care worker

The reference to 'nice calm house' displayed Jackie's observation skills in assessing domestic environments. The phrase, 'they can see your body language' is another illustration of Jackie's interest in non-verbal communication. She explained it would be natural for care workers to feel stress due to a busy schedule, 'with the adrenaline going'. However, the temptation to start 'panicking' and 'flapping' should be resisted because it may be detrimental for the client – it could 'put them right off'. The solution, according to Jackie, was

to portray an aura of calmness. In the same vein, Matthew used judgement to select an appropriate tempo for client interaction.

When you go into somebody's home, what sort of energy do you want to bring into that environment? Yeah? Now, if you're rushed off your feet, you got all those things to do in 45 minutes or you've got a half an hour visit, the energy that you bring in is cheerful, high energy but we're not wasting time doing anything unnecessary type energy. And I think that's a barrier to communication, it's a barrier to all of the things I said when I gave the first example of what I mean by person-centred care, which is, you know, have you got to know them better, have you left them in a state of calm serenity and reduced anxiety, because actually all of that energy is about getting through the care plan as fast as possible because you haven't got time.

Matthew, CW005, community care worker

Like Jackie's assessment of her own behaviour in the context of a client's domestic environment, Matthew demonstrated awareness of his 'energy'. Any negative energy might form barriers to communication, from Matthew's perspective, and limit opportunities to create an atmosphere of 'calm serenity and reduced anxiety'.

These examples suggested Nurturing Mental Health practitioners' interest in the psychology of caring interactions had come full circle. Their ability to observe clients' facial expressions, emotional reactions, and body language was turned on themselves. Reflexive self-awareness, hiding negative emotions, and charisma, appeared to be key skills in delivering person-centred care from a Nurturing Mental Health perspective.

This chapter has offered an overview of meanings attached by Nurturing Mental Health participants to person-centred care. To shed light on beliefs and values surrounding these practices, it is instructive to consider how they came to their understanding. This is discussed in the next section.

6.10 Sources of knowledge of person-centred care for Nurturing Mental Health members

The most common reference point for gaining an understanding of person-centred care was life experience within Nurturing Mental Health. The allocation of participants is shown below.

Table 6.4: Key sources of knowledge of person-centred care – Nurturing Mental Health

Source of knowledge	Number of participants	Name
Life experience	3	Jackie, Becky, Louise
Training and development	1	Matthew
Independent study	0	

The three participants citing life experience talked about experiences from their personal lives and family background. This knowledge was often combined with common sense principles. For example, Louise explained:

Well, my daughter's deaf. So that's - the thing is, it's in me anyway, is the fact that I always see the person.... But being my daughter's deaf, you have to be her advocate until she could cope with not hearing.
Louise, CM007, residential care manager

Knowledge gained from being her child's advocate and supporting her to cope with deafness offered valuable learning experience, according to Louise. The participant hinted her interpretation of person-centred care was influenced by innate personal values: 'it's in me, anyway, is the fact that I always see the person'. In a similar vein, Becky's relationship with her grandmother, whom she looked after, was an important source of knowledge. When asked what aided her understanding of person-centred care, she said:

I went on to look after my gran, and had to try and work out the same things, really. I had more time with my gran. So more on a personal level, I'd say. That would help me to understand why it's so important.

Becky, CW008, community care worker

A fellow member of Nurturing Mental Health, Jackie, talked about life experience and common sense when it came to delivering person-centred care.

Sometimes it's common sense. You kind of, like I said, you pick up on their body language, if they don't like it you don't do it, if they're getting wound up, don't do it.

Jackie, CW002, community care worker

Her example of honing in on body language reinforced the importance of psychological assessment as a skill for Nurturing Mental Health, as explained in Section 6.6.

Matthew was the only participant who talked about training and development in terms of sources of knowledge of the concept. He said he had learned about the sector-wide definition of person-centred care from the Care Certificate, while hinting at developing his own way of thinking:

Your question was how did you develop your approach to person-centred care, how did you, you know, how did you come into your way of thinking about person-centred care. By putting a lot of effort into it. Why did I want to put a lot of effort into it, because it's the most interesting part of the job for me.

Matthew, CW005, community care worker

The claim that Matthew had put 'a lot of effort into' thinking about person-centred care implied some level of independent study. However, he did not give any specific examples of this, whereas the Care Certificate was a clear example of professional training, hence Matthew's allocation to 'training and development'.

The data extracts here illustrate how participants drew from personal principles and experiences to develop an understanding of person-centred care. Training was not cited as a strong source of knowledge – Matthew did mention the Care Certificate but also said he had developed his own way of thinking. This finding suggested Nurturing Mental Health perspectives of person-centred care were based on individual interpretations of the concept, without strong reference to official policy guidance.

6.11 Concluding comments

This chapter has presented a theory of person-centred care as a conduit to nurture older people's mental health. Members demonstrated attentiveness and skill in reading psychological and behavioural traits of clients - crucial facets of practice in Nurturing Mental Health. Participants talked about tapping into nuances of clients' moods and personalities and adjusting their persona appropriately. This may have involved downplaying negative emotions - adopting a poker face - or drawing on natural charisma to play to the gallery. There was heightened awareness of domestic settings: community care workers in the group spoke of the uniqueness of the milieu they encountered in different settings. Occasionally, client outcomes were only tacitly understood. For example, Becky's account of an older client's reaction included a disclaimer of *taking* it to be happiness. Perhaps uncertainty was to be expected, given the subjective nature of mental health.

Matthew explained he had developed his own understanding of person-centred care, which had become the most interesting part of the job in his opinion. Others cited experiences from childhood or parenting as influencing their understanding of the concept. There was a sense of freedom from institutional frameworks, as practitioners did not talk about official sources of information regarding their understanding of person-centred care. Overall, the members'

values, beliefs and practices combined to form a clear focus on creating positive mental health outcomes for clients in their care.

The second group in the typology, Nurturing Agency, is described in the next chapter.

Chapter 7: Nurturing Agency

'You butter the bread and I'll make the tea.'

Daisy, CW012, community care manager

7.1 Introduction

In this group within the typology, practitioners were interested in nurturing the voice, strengths, and overall human agency of the older people they were supporting. This chapter presents the results of analysis from Nurturing Agency, the largest of the typology in terms of participant numbers. The group takes its name from the idea that members attempted to encourage people's agency by providing opportunities for physical and mental capacity to be exercised. This furthering of capacity is exemplified in the quotation at the top of the page, in which Daisy quoted a typical conversation between herself and a client. She would encourage clients to carry out simple tasks themselves in the hope they would retain those abilities for as long as possible.

Findings in this chapter are preceded by a preliminary section with a list of the members' names and job titles, and brief description of the model. A pen-picture based on the individual narrative of one of members illustrates the interests of the Nurturing Agency group from a first-person perspective. The chapter includes discussion of some caveats to the implementation of this style of person-centred caring, as not all decisions could be devolved to clients. Subsequent sections identify the rewards experienced by participants, and concluding comments. Analysis of data suggested, when seeing the person they were supporting, Daisy and other Agency members looked beyond possible deficits to notice strengths. They stimulated personhood by encouraging decision-making capabilities, and sought to empower clients to live

their lives on their terms. The overarching objective, it seemed, was to delay the rate of decline linked to illness and ageing.

7.2 Overview of Nurturing Agency

The ten members of the group are listed below.

Table 7.1: Members of Nurturing Agency

Participant number	Participant	Job status	Setting
CW003	Nadia	Self-employed care worker	Community
CW004	Jennifer	Self-employed care worker	Community
CW010	Nicola	Self-employed care worker	Community
CW011	Elena	Self-employed care worker	Community
CW012	Daisy	Provider-employed manager	Community
CM001	Kelly	Provider-employed manager	Residential
CM003	Charlotte	Provider-employed manager	Community
CM004	Lucinda	Provider-employed manager	Community
CM005	Victoria	Provider-employed manager	Residential
CM006	Melissa	Provider-employed manager	Residential

This table shows the group had the highest concentration of managers – six in total – out of the whole typology. It also had the highest number of provider-employed professionals, as opposed to self-employed. One possible explanation of these findings was that managers of care homes and community

care providers were most likely to work closely with policy frameworks, because implementation of official regulations was their responsibility. Support by managers for Nurturing Agency was to be expected, therefore, because this perspective aligned with key principles of the Care Act (2014), such as empowerment and autonomy. (The most prominent sources of knowledge cited by members of Nurturing Agency are explained in Section 7.8.)

The key practice components of Nurturing Agency are represented by the diagram below.

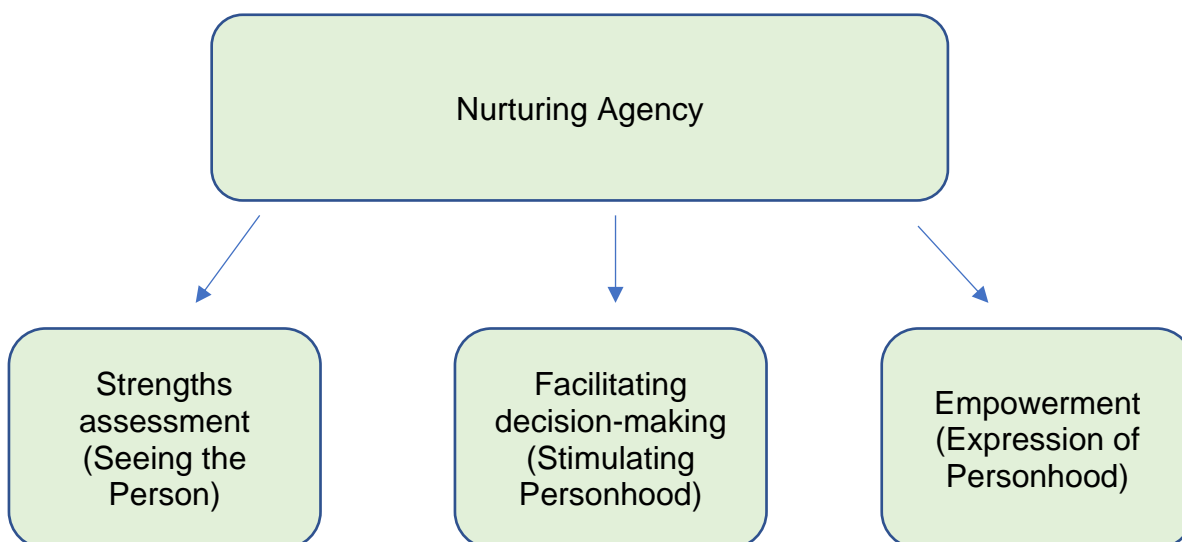


Figure 7.1 Key components of Nurturing Agency perspective on person-centred care

Strong articulations of this person-centred interpretation were noticeable in Victoria’s interview, whose pen-picture is presented below.

7.3 Pen picture introducing a Nurturing Agency member

Victoria, 50s, manager of nursing home, South West England

“I’m a qualified nurse and registered manager of a nursing home. I started off working as a care assistant nearly 30 years ago and worked in hospital wards and neurology, and now I work in long-term care. I enjoy working with older people. They’ve got a wealth of experience and amazing personalities. They’re only old because of their age, if that makes sense.

My residents all come from different backgrounds. They all have different needs – so, a bit like me and you, we would have different values, different hobbies, different likes and dislikes. It’s almost easier to understand person-centred care by thinking about what is the opposite: institutionalised care. If you can imagine an old hospital where there’s a row of hospital beds and you’ve all got your hospital nightie on and you’re all there, everything at the same time.

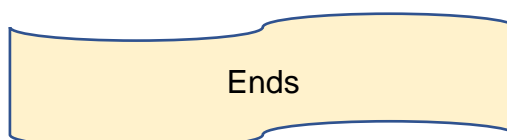
There’s been some big changes in healthcare since I started working. It’s not the old days of ‘matron’ and patients doing as they’re told. They [clients] make decisions and you help them live their life the way they want to live it. You’re trying your utmost to actually deliver care to that person so they can continue to be the person they want to be, then they’re going to have quality care, as opposed to not having quality care. You are like a friend but you have to have some professional distance as well: there is a beginning and end to the relationship. That is my understanding of person-centred care: it’s about choice and helping people feel empowered.

It’s about not taking away their sense of power, their choices. There’s definitely been a big power shift in healthcare. Obviously if someone wants to go swimming in the Channel or something that might be quite hard to achieve for

most people, because you have to think about their safety. So there are lots of barriers to achieving person-centred care.

If I was supporting Linda I would try and find out more information and speak to her. She's possibly got quite a lot in her long-term memory. We know that she likes to garden, so we've got somewhere to start from. I would certainly try to find a way to help her do that. Moving forward there's quite a few things I would do to help out with a future life, so I would try and make sure she was having the best treatment that she could. So that she can do more, for as long as she can. Anything that will aid her with her walking, or even some medicines such as memory drugs.

I go to work every day to do care and I want to be able to make a difference, really. I want to feel fulfilled and the way you do that is by seeing people flourish. The people who live here in the nursing home are no different to you or me. We have parts of our lives that we look back on that we've enjoyed, don't we? Whether it be childhood, school, work, and marriage. And when you reach old age you should be able to enjoy that stage of your life just as much as any other stage."



Reflections on Victoria's pen picture

Victoria's approach to care appeared to embrace a holistic vision of personhood, founded on diversity, empowerment, and freedom of choice. Her care practice was distinguished by a can-do philosophy, represented by the plea in the third paragraph to 'imagine maximising everything about the

person's life as much as they possibly can do things'. She believed person-centred care was 'about choice and helping people feel empowered'. There was a recurring theme of the transfer of power and decision-making to the client, as indicated by references in Victoria's interview to 'power shift' and 'power, their choices'.

As a counterpoint to her understanding of person-centred care, Victoria depicted a negative vision of how institutionalised services might damage people's agency, represented by an image of 'an old hospital' and patients wearing regulation night-dresses. Victoria seemed determined to avoid an environment where organisations, not clients, held sway. She championed the possibility of creating a 'future life' for clients. The right to make decisions should apply to everyone, regardless of age, suggested Victoria, who seemed influenced by a strong desire to promote equality for older people.

Victoria felt strongly older people should not be discriminated against: 'The people who live here in the nursing home are no different to you or me.' Her upbeat visualisation of ageing implied a downplaying of vulnerability, projected by the argument that older people can continue to flourish, on the assumption of equality for all. She envisioned using skills and experience to slow the rate of decline within older people's mobility and memory, to allow them to enjoy this future life. This approach was noticeable in her response to supporting Linda, the fictional client. Victoria's interest in supplying memory drugs and walking aids to Linda suggested a desire to extend clients' physical and mental capacity into later life.

The desired outcomes of Victoria's understanding of person-centred care were clear: empowering individuals to make decisions and 'seeing people flourish'. Victoria said she goes 'to work every day to do care and I want to be able to make a difference'. Seeing residents enjoy life on their own terms could be highly fulfilling, it seemed. Ideas reflected by this pen-picture were evident in the

transcripts for other Nurturing Agency participants. Discussion of these attributes begins with the assessment of people's strengths.

7.4 Seeing the Person: strengths-based assessment

Analysis suggested a strong interest in assessing people's strengths in the Nurturing Agency group: this formed the first stage of practice. As seen in the previous section, Victoria's interest in facilitating clients to exercise capacity formed the foundation of her interpretation of person-centred care. She explained:

Now, if you can imagine maximising everything about the person's life as much as they possibly can do things. You try and facilitate them for things they can't do, but you don't take over.

Victoria, CM005, residential care manager

Here, the manager's remit appeared broad: to maximise everything in a person's life, 'as much as they can possibly do things'. Victoria depicted herself as facilitator, rather than care-giver – an observation substantiated by the phrase, 'You try and facilitate them for things they can't do'. Prior to the act of facilitation, one of the prerequisites of the Nurturing Agency approach was assessment. The objective was to identify strengths of older people they were supporting and find ways of emphasising those strengths in practice. Victoria's discourse concerning a person's ability to 'do things' implied she must pinpoint what those things might be, while distinguishing from 'things they can't do'.

These limitations to capacity would be determined, alongside strengths, during assessment. Nicola offered an example of how she interacted with one of her clients while offering personal care, with these boundaries in mind.

Because of the leg, of the feet, you know. She cannot take up the feet. So I just give her strip-wash and sometimes she wanted to do herself so I, I cannot say, 'OK, let me do it, not you.' You know. That is person-centred care! So when, when she wants to do something, you should leave her. Of course, if everything is, you know– it's OK. You - it's safety, and that's it.

Nicola, CW010, community care worker

Nicola's thoughtful approach to facilitating a client's washing suggested it followed a period of assessment, in which the care worker gauged the person's capacity. In this scenario, Nicola noticed the person's ability to wash parts of her body, while struggling to reach others. Nicola was careful not to interfere with the exercising of the client's available capacity and consciously avoided saying 'let me do it, not you'. This, she argued, was the essence of person-centred care, evidenced by the participant's direct description of the concept: 'That is person-centred care!' The only exception, from her perspective, was intervening when a person's safety was at risk.

The assessment of strengths was led by the care professional, but conclusions were not necessarily reached unilaterally. The process could be complex and require skilful mediation between professional and client, as this passage from Nadia's interview suggests. The client in question had chronic mobility problems which she worried might prevent her from enjoying some activities, such as days out. It appeared Nadia's assumptions were initially at odds with the views of her client, however.

Well [one of my clients] often said, 'Oh, I don't, you know, I don't think I'll ever be able to go to the beach again.' I said: 'Don't be stupid, you can, you know, we will.'

And she'll often say, oh, to go over to [name of beach] again, and, you know, it was just nice to say, like, 'We're off, we're doing it!'

Nadia, CW003, community care worker

This extract illustrated a series of tacit judgements on the part of the professional. While seemingly aware of the client's physical limitations, Nadia

seemed to downplay these and emphasise her right to exercise choice. The reported speech recalled by the care worker– ‘you can, you know, we will’ – represented attempts to encourage the client to share her professional judgement. As a result, she persuaded her to continue enjoying outdoor activities. Part of the professional’s remit, in this Nurturing Agency interpretation, was to use interpersonal skills to encourage clients to accept the results of their strengths-based assessment.

An extract from another participant in Nurturing Agency provided further evidence of strengths-based assessments, in a comment regarding an imagined client.

We would assist with – supervise her having a wash, or a shower and we would say, ‘Can we help you with your back, ‘cos you can’t reach that.’ To ensure that she – her personal hygiene was up together.

Charlotte, CM003, community care manager

In this depiction it was implied Charlotte had assessed the person’s capacity, and had apparently concluded they could perform part of the washing themselves, because the client was described as ‘having a wash’. When it came to the professional’s role, it was notable Charlotte began by describing her input as ‘assisting’, then appeared to stop and correct this by using the word ‘supervise’ instead. Building on the observation at the beginning of this section, Charlotte’s advocating of supervision over assistance was similar to Victoria’s self-portrayal as a facilitator rather than care-giver. The client in this scenario enjoyed the benefit of continuing to exercise physical and mental capacity.

Sometimes agency-focused practitioners needed to show a flexible approach, depending on individual circumstances.

I think with dementia clients...routine is important and reminding them about places they like. So it’s good to talk about what is client’s favourite route, what is favourite

park, bench, you know, favourite view she enjoy. Stuff like that.

Elena, CW011, community care worker

In this extract, Elena appeared to use her knowledge of cognitive impairment to emphasise the long-term memory of clients with dementia. Though seemingly innocuous, the memory of a 'favourite view' or favourite park' could be a treasured link to the past, and Elena seemed eager to encourage the retention of these memories, especially for people with dementia. As the care professional said, 'routine is important' for such people, a viewpoint implying that capacity, and by extension, independence, could be sustained by rote. In other words, older people should be supported to keep doing things they have always done. This argument was reinforced by Kelly, a care home manager, and her approach to coordinating person-centred care for Linda, the fictional client.

The fact that she's been living by herself for quite a long time and she's only got some memory loss means that she could still be fairly independent.

Kelly, CM001, residential care manager

The response appeared to show an interest in client strengths. Kelly acknowledged Linda had 'only got some memory loss' and had been living alone for some time, suggesting an immediate recognition of some independence on the part of the client.

These examples have illustrated methods of identifying client strengths to inform person-centred care planning from a Nurturing Agency perspective. The initial assessment laid the groundwork to see the person by understanding their strengths and capacity. The next stage of practice was to stimulate personhood through enabling client decision-making.

7.5 Stimulating Personhood: facilitating decision-making

Part of the Nurturing Agency conceptualisation of person-centred care involved understanding a client's physical and mental capacity. Practitioners paid attention to client agency and viewed decision-making regarding care and support as a fundamental part of exercising that agency. Nurturing Agency members sought to devolve these decisions to clients as much as possible, framing clients as autonomous actors capable of choosing the direction of their support. This approach would help to stimulate the client's personhood, they believed, and this point was made repeatedly in interviews with these ten members. It appeared in arguments made in response to interview questions, and practical examples to support those arguments. Lucinda discussed this subject regarding her clients.

We ask them what time would they like to get up, would they like an early visit or a later visit – yeah, giving them personal choices, preferences. Being respectful and responsive to them and their values and decisions. Not our decisions, their decisions.

Lucinda, CM004, community care manager

Here, Lucinda discussed using interpersonal skills, asking questions and making suggestions – demonstrated by the phrases, 'ask them what time they would like to get up' and 'giving them personal choices' - to ascertain the client's wishes for the direction of care. Lucinda stressed clients were best placed to choose, evident in the phrase, 'Not our decisions, their decisions,' appearing to downplay her professional input while playing up the person's decision-making capacity.

Being responsive to a client's decisions implied they might have received free rein to do whatever they chose. However, analysis suggested in practice, communication by group members involved some steering on the part of the professional. For example, Lucinda suggested how she might approach supporting Linda, the fictional client.

Again, you know, give her [Linda] the choice, would she like to go and have a little wander round the garden while we're there, with her frame to make sure she was safe, and fresh air, 'cos at the moment, you know, they're not getting out.

Lucinda, CM004, community care manager

The wording of the question directed at Linda by Lucinda was not open-ended, as one might have expected if clients were given total freedom of choice. Instead, it was framed as a suggestion: '[W]ould she like to go and have a little wander round the garden while we're there?' The use of leading questions implied professionals did not simply devolve all decision-making to clients without any input themselves. Instead, their style of practice involved floating ideas and suggestions. The example above implied that some client-worker communication would include the use of closed questions, e.g., 'Would you like to do x?', which projected a yes/no answer, as opposed to an open question: 'What would you like to do?'

Another practical example of the stimulation of people's decisional capacity was from Jennifer, who described support she had given to a former client.

You can only do good work with somebody and help them to live their life that they want to if you've got that rapport going in the first place, and if you don't, kind of like, take the time to kind of understand, you know, how they'd want to do things, you know, preferences on things like eating or where they like to go or what music they like to listen to, or, you know, with the lady that I was talking to, like even down to, you know – I helped her to put together a 'do not resuscitate' stuff and all of the stuff that went with the power of attorney and she had some really, really strong views about whether she did or didn't want to be resuscitated.

Jennifer, CW004, community care worker

The wording of Jennifer's account implied syntactical connections between 'good work' and helping people 'to live their life that they want to' – phrases appearing in the same sentence. The proximity suggested respecting people's

wishes and stimulating individual agency were central to her understanding of care quality. Jennifer sought to develop knowledge of the client's preferences – from something as apparently trivial as their favourite music, to more sober, substantive topics such as end-of-life care. She seemed to view this knowledge as a key asset in enabling the person to exercise mental capacity. Jennifer stated her client had 'really, really strong views' about medical treatment in the event of critical illness. This was a clear example of respecting the person's capacity to decide, presumably coming about because of Jennifer's interpersonal skills in eliciting in-depth knowledge of the person's character and opinions.

The concern with decision-making agency was a theme running throughout Daisy's interview. It was first witnessed in Chapter 5, which noted her talking about avoiding family members making decisions on the client's behalf. Another example is shown in the extract below.

Once the wash was done we'd go into the kitchen and then do, like, the breakfast. While we're sat at the breakfast table, I would be, like: 'What would you like for breakfast today?' Give her all the options. Making a cup of tea or coffee, whatever they drank, making sure they always have the options, what would you like, tea, coffee, cereal, toast. Things like that, jam or marmalade. Or cooked breakfast, whichever they wanted.
Daisy, CW012, community care manager

This comment represented a thorough explication of Daisy's diligent, interpersonal approach, presenting detailed choices—to the client - 'tea, coffee, cereal, toast...jam or marmalade. Or cooked breakfast.' The desire to give clients 'all the options' appeared to encourage clients to express themselves in the knowledge they would be listened to. The use of the first-person plural pronoun, 'we' (noticed in the phrase, 'we'd go into the kitchen'), implied a collaborative attitude towards caring.

Sometimes communication problems could be a barrier to facilitating decision-making. Melissa, who supported people with dementia, described using visual aids in such situations.

We would obviously show [residents with dementia] different things if they're not able to make a choice, so at lunchtime on our dementia unit we wouldn't just say, 'It's ham, egg and chips or it's lasagne for lunch.' Because those words don't necessarily mean a great deal to them so we would plate up one of each and we would take it to them and say, 'This is the lasagne, or this is the ham, egg and chips.' And they can actually look and decide with their eyes which one they fancied because they might not know what it's called anymore but visually they would know what they like the look of.

Melissa, CM006, residential care manager

This scenario provided an idiographic case of nurturing an older person's voice through skilful application of non-verbal communication, where someone's cognitive faculties were impaired. Visual aids were necessary because verbal communication would not 'necessarily mean a great deal to them', according to Melissa. Listening to her account of mealtime planning, it was easy to imagine a warm, relaxed exchange between herself or another colleague and an older person, pointing to plates of cooked meals and asking whether they 'fancied' this one or that one. The extract offered a vivid example of Melissa using interpersonal and organisational skills to promote decision-making capacity among older people.

The value of individual agency to an overall vision of person-centred care could not be overestimated, according to Charlotte.

Absolutely, and I think that's the most important thing, if you can, if you don't allow them to make their decisions and you take over their decisions for them, you know, they have no quality of life, they have no input into how they want to live their life.

Charlotte, CM003, community care manager

The argument was presented in stark terms: without the ability to make decisions, adults would have ‘no quality of life’ and ‘no input into how they want to live their life’. Their sense of agency was ‘the most important thing’. Charlotte’s expression of this belief underlined how strongly she linked the concept of well-being to decision-making capacity.

These data extracts have illustrated the relevance of decision-making among older people, and the skills used to encourage this capacity, in an overall interpretation of person-centred care. The kind of decisions could range from seemingly insignificant, such as choice of music, to weightier matters, such as resuscitation orders in the event of serious illness, but all pointed to enabling clients to live their lives in a manner agreeable to them. Having established a person’s strengths (Seeing the Person) and encouraged decision-making (Stimulating Personhood), practitioners hoped to nurture agency and empowerment within older people. Such an outcome was an expression of personhood in the Nurturing Agency approach, which will be discussed next.

7.6 Expressions of Personhood: empowerment

This section discusses participants’ beliefs regarding the objectives of stimulating agency among older people. It will examine the scope of outcomes – expressions of personhood – assumed by care workers and managers sharing a Nurturing Agency outlook of person-centred care.

Initial themes on this subject were introduced within the pen-picture in Section 7.3, where Victoria talked about empowering people to ‘continue to be the person they want to be’. This was one of the central assumptions underpinning the strategy, which relied on in-depth knowledge of the person’s own desires and interests, as suggested by Nicola:

You should know what they [clients] like, so you should ask what they like to wear in that day, or, you know. What colour they like, what - you know, it's everything focusing on them, not, you know. Because sometimes in their plan is not write everything, you know? You, you like a carer or personal assistant, or whatever. You should know better than anybody else. What they need, and, you know, to, to empower them, to live independent life, in a way.

Nicola, CW010, community care worker

The anticipated objective, according to Nicola, was to 'empower' clients 'to live independent life'. She highlighted a potential administrative barrier, that care plans could be mechanistic and limited – 'sometimes in their plan is not write everything'. The onus was on care staff to elicit choices on a recurring basis, filling in potential gaps in care plans to reflect people's changing preferences and help achieve the desired state of independence.

Other participants discussed the idea of 'involving' clients in their care.

I think person-centred care enables you to provide good quality care 'cos the person is involved in their care and you're encouraging them to be as independent as possible.

Charlotte, CM003, community care manager

Charlotte had already indicated an interest in working in partnership with clients, as illustrated by her emphasis on 'supervision' rather than 'assistance' in the analysis in Section 7.4. Here, she referred to the person being 'involved in their care'. Taken in the context of other extracts (such as the one from Nicola, above), the reference to involvement appeared to relate to the client being invited to participate in the direction of care, by offering opinions on how things should be done. This would encourage feelings of independence, according to Charlotte, who explicitly linked this with the concept of person-centred care.

Similarly, Lucinda described encouraging clients to do things and make decisions in relation to their care.

A gentleman that we go to, he knows exactly how he would like his care. He has multiple sclerosis, he makes it very clear what his needs are. He chooses, would he like to get dressed in these clothes or these clothes. What would he like for breakfast, it's personal choice. I respect his wishes. I try and give him the independence when he can do things, you know, not to take over because of timing or I'm in a hurry or anything, 'cos you must still promote their independence. Don't take away from him the things he can still do. They may be limited but he can still do.
Lucinda, CM004, community care manager

The client in this passage was positioned as an expert and equal partner. There was an overriding feeling of decisional autonomy indicated by wording such as 'he chooses' and 'he knows exactly how he would like his care'. Lucinda positioned the client as the subject of the sentence, driving and governing action. The focus in this extract was on promoting independence, nurturing capacity, and trying not to 'take away from him the things he can still do', however limited they may be. The temptation may have been for the professional to take control due to time constraints – 'not to take over because of timing' – but Lucinda felt this should be resisted. These concepts of empowerment and capacity appeared important facets of Lucinda's care practice and understanding of person-centred care.

Daisy offered another example of empowering someone to maintain capacity. She explained her approach towards a typical interaction with a client in their own home.

'Cos you're always trying to promote their independence, as much as possible, so it could even be, well, 'You butter the bread while you're sat at the table and I'll make the cup of tea', and things like that. Or: 'You put your own sugars in your tea, 'cos I don't know how many you want.
Daisy, CW012, community care manager

This homespun vision of shared duties, with Daisy making tea while the client prepared food, was a charming distillation of the Nurturing Agency philosophy (as hinted by the opening extract of this chapter). The invitation to participate in food and drink preparation – ‘You put your own sugars in your tea, ‘cos I don’t know how –any you want’ - was framed as an innocuous suggestion. In fact, Daisy’s feigned ignorance seemed part of a wider strategy of skilfully empowering clients to continue undertaking activities of daily living themselves, and making their own decisions, with the aim of stimulating well-being. As Daisy said, ‘you’re always trying to promote their independence, as much as possible’. The scenario showed the significance of even the smallest of everyday gestures in the framing of person-centred care, as a means of maintaining physical and mental agency throughout old age. Further confirmation of this empowerment-focused perspective came from Elena.

But in normal situations, carers should be, like, in background. Getting them ready to enjoy life. And they feel great, because you are enabling them and, to really enjoy life, to be ready for anything. Even if they can - cannot do it themselves, you get them ready for life.

Elena, CW011, community care worker

Elena adopted an upbeat, optimistic tone, reflected in remarks about feeling ‘great’, enjoying life, and being ‘ready for anything’. Her comment also carried implications for the role of care workers in this version of person-centred care, with the idea that carers should be ‘in background’. This argument resembled the findings of linguistic analysis in Chapter 5, where professionals were positioned as peripheral figures in an interpretation of person-centred care. In Elena’s extract, there was no reference to impairment or deficiency typically associated with old age. Her preferred outcomes for her clients appeared to be focused on living, not ageing.

This section has explored meanings attached to person-centred care from a Nurturing Agency stance in terms of the empowering effects they wished to

have on clients: expressions of personhood. The approach appeared to hold rewards for practitioners, which are discussed below.

7.7 Rewards for care professionals

Members of Nurturing Agency reflected on the effect of delivering person-centred care on themselves, and were highly positive when they believed good outcomes had been realised. The professional rewards were clear to see in several cases. Nadia, for example, reflected on the anecdote cited in Section 7.4 about persuading one of her clients to go to the beach. In relation to this, Nadia commented:

Because I do find it so rewarding, just to know that, you know, you've delivered exactly what she wanted and hoped for 'cos I mean it, some care, some care companies you know – 'You're bed-ridden, that's it, you know, you're not getting, the chance of going out again is, you know.' So yeah it's lovely to just be able to do things that they think they probably won't ever do again.

Nadia, CW003, community care worker

Nadia explained she found it 'so rewarding' to see someone overcome self-doubt by exploring the local community: a 'lovely' feeling, she said. The participant seemed to take pride in surpassing what she considered low expectations from 'some care companies'. Her imagined response suggested these companies would declare some clients 'bed-ridden, that's it' and accept the status quo without trying to empower them. This attitude appeared to amount to a collective shrug of the shoulders, which Nadia was determined to avoid.

A fellow participant sharing the go-getting attitude of Nadia was Jennifer, who took pleasure in confounding normative beliefs about ageing and disability

through her care practice. This extract was preceded by an anecdote about arranging a special Christmas carol service for a client nearing the end of life.

It made me feel brilliant because I could see, I could see what – you know, how much pleasure [one of my clients] got from it, and it was just a little bit of a opportunity for her to be able to, kind of, like, go back to life when it wasn't quite so isolated, I guess, 'cos that – that was the main problem, it was kind of like trying to keep her, I don't know, trying to keep her brain active, more so.

Jennifer, CW004, community care worker

From Jennifer's perspective, reward was derived from seeing a client progress towards the outcome of keeping 'her brain active'. This was one of the central objectives of a Nurturing Agency perspective, of maintaining mental capacity. The care professional seemed to feel great satisfaction – 'it made me feel brilliant'.

In more general discussion, people outlined the feeling of delivering person-centred care from personal perspectives.

I think it gives everybody a real buzz because when they've achieved something with somebody and it's really working.

Kelly, CM001, residential care manager

Kelly's observation, it 'gives everybody a real buzz,' suggested she viewed person-centred care as a collective enterprise involving the team. Other members of Nurturing Agency shed light on their feelings.

Of course it feels great when you know that even if the person can't do much by themselves in their everyday life, you provide care and they feel like they can do things again.

Elena, CW011, community care worker

Elena drew association between the idea of person-centred care and restoring a person’s capacity to ‘do things’. When Elena thought this had been achieved, she said, ‘it feels great’. Nicola also raised the idea of improving a person’s capacity as a measure of effective, person-centred care.

Yes, the lady had a stroke and couldn’t move the left leg, and the left hand. So she couldn’t do many things. But I help with physiotherapist and she was recovery after one year. I am quite proud of that because I left her well. Very well.

Nicola, CW010, community care worker

Watching a client recover their physical ability seemed a source of great professional pride. These extracts have offered insights into participants’ glowing emotional and professional responses when performing person-centred care, from the perspective of Nurturing Agency. In addition to analysis of Nurturing Agency practices, it is important to examine underlying knowledge behind these beliefs. This topic is discussed in the next section.

7.8 Sources of knowledge of person-centred care for Nurturing Agency members

Several sources of knowledge influencing people’s interpretations of person-centred care were mentioned in interviews. Table 7.2 presents allocation of participants to different categories.

Table 7.2: Sources of knowledge of person-centred care for Nurturing Agency members

Source of knowledge	Number of participants	Name

Training and development	7	Nadia, Elena, Charlotte, Lucinda, Kelly, Victoria, Melissa
Independent study	2	Jennifer, Nicola
Life experience	1	Daisy

The most prominent source of knowledge for Nurturing Agency was training and development, with seven participants citing this. Two said independent study was a key resource, and one life experience. Of the seven citing training and development, five were managers and two workers. The suggestion that managers were most likely to gain knowledge of person-centred theory through training was a notable finding. Some of the participants cited organisational training arranged through their employers, and national bodies such as the Care Quality Commission as information sources. For example:

Probably, over the years, sort of different training sessions that we've had. Normally a lot of training sessions around dementia would have a good section on person-centred care and different approaches and adaptations. A lot of stuff that the CQC send out I would probably refer to that. Or have done in the past.
Melissa, CM006, residential care manager

Melissa explained she had learned from training sessions which included information about person-centred care. The implication was she may have acquired knowledge about a Nurturing Agency perspective of person-centred care through 'stuff that the CQC send out', in the context of references to human agency in other parts of her interview. Other managers pointed to the ubiquitous nature of person-centred care as a development topic.

Well, over the years, most of the study that I've done has included it. I haven't looked at anything specific that's just about that. Funnily enough this behaviour that challenges course that I'm doing at the moment, is quite specific to person-centred

care, really.

Victoria, CM005, residential care manager

Victoria explained most of the study she had done had covered person-centred care. By referring to a specific training course after this statement, I took the reference to studying to mean general training and development linked to her job, as opposed to independent study. Both Victoria and Melissa used the identical phrase, 'over the years', which spoke to the prominence of the concept across their managerial careers.

Nurturing Agency workers discussed learning about person-centred approaches. Elena was positive about her experience of studying for a Diploma certificate.

Yes, especially when you, when you read those materials– and when you - there's good way, of I think, studying and learning when you work with client and at the same time you, you go through materials and books about how it's done, and then this diploma, like, helps you to compare theory with practice... Yeah, it was interesting.

Elena, CW011, community care worker

Among participants allocated to different categories, Nicola (CW010) and Jennifer (CW004) cited the Human Rights Act (1998) as an information source. For example, Jennifer said:

I always think it's worthwhile kind of going back to Human Rights Act. Just as a bit of a reminder, you know, I think, particularly with older adults, that kind of like little reminder that everybody does have privacy and, you know, a right to a family life I think is helpful.

Jennifer, CW004, community care worker

Jennifer's interest in the right to privacy was reflected in comments from Nicola, who mentioned studying the Human Rights Act (1998) in her own time:

I like to know, just f-r myself...It's - I know it's the direction of human rights...It's about, you know, the rights of a person.

Nicola, CW010, community care worker

Nicola appeared strongly influenced by the focus on individual personhood in human rights legislation, making numerous references to 'the person' in her interview.

While these examples illustrate an inclination towards legislative and regulatory policies, one respondent, Daisy (CW012), cited life experience.

Obviously had nan and grandad. Grandad was poorly when I was young, and I did watch him deteriorate quite rapidly. And obviously my d-d who doesn't - good health, so yeah I think in all of that, I just, like, treat people how I would want my family to be treated.

Daisy, CW012, community care manager

Daisy seemed to take her family background as a reference point for understanding person-centred care. In the overall context of Nurturing Agency participants, this seemed an exceptional case. The most common sources of knowledge for the Agency group were official policies supplied by employers and training providers, according to an overall analysis of responses.

7.9 Concluding comments

This understanding of person-centred care from a Nurturing Agency standpoint made a significant contribution towards the typology. Participants appeared to define the concept of person-centred care through agency-related outcomes: keeping people's brains active, enabling physical exercise, supporting people to make everyday decisions. The exercising of agency encouraged by these

practices could be simple, everyday gestures, such as buttering toast, or loftier goals. The key was that they would be conducted on the terms of the client. Practitioners were interested in protecting the integrity of older adults' voices, apparently in an attempt to confound ageist attitudes and the marginalisation of older people in society.

One of the most striking interview excerpts was Lucinda's axiom, of trying not to take away from clients things they could still do. This belief appeared to carry both a sense of optimistic aspiration and reality. Aspirational in its concern towards strength and capacity, rather than deficiency; and realistic in an underlying acknowledgement that limitations in a person's capacity may need to be addressed through care and support. It was a case of supervising and facilitating, rather than doing on behalf of. Participants talked about involving people in their care. The idea of involvement appeared to suggest consulting clients directly and encouraging them to determine the direction of care and support, either through making decisions, taking action, or both. Involvement had the potential to boost self-esteem by positioning the client as someone whose views were valued. Such participation would allow the exercise of physical and mental capacity, with the aim of slowing the rate of decline, in the view of Nurturing Agency members.

There were boundaries to Nurturing Agency. For example, Lucinda's use of closed questions in Section 7.5 suggested some steering on the part of professionals in encouraging clients to make decisions. Freedom of choice could not be completely open-ended: while choice was a principal concern of participants, in practice it may have been offered in terms of what could be realistically delivered. However, the overarching assumption was that the client was (or was capable of becoming) an empowered, independent individual.

The third and final group of the Typology, Nurturing Intimacy, is explained in the next chapter.

Chapter 8: Nurturing Intimacy

*I've always said [to clients], 'I'll never leave you.' And I haven't.
I'll always stay.*

Maggie, CW006, community care worker

8.1 Introduction

In this final strand of the typology of person-centred perspectives, participants embraced the relational side of care. Acknowledging deficits of older people, Nurturing Intimacy members described holding, giving, and listening in their caring roles, often developing camaraderie and strong emotional bonds with clients. In this understanding of person-centred care, participants sought consent to provide intimate care and used phatic engagement to make the caring process more pleasurable for the client. The outcome was the development of intimate caring relationships, even friendships, with people they supported.

This chapter describes the administrative and interpersonal skills used by professionals to achieve these aims, beginning with an overview of typological group members. A pen-picture introducing one individual is followed by descriptions of the core stages of practice of Nurturing Intimacy. Subsequent sections describe emotional responses by participants towards their clients, and the most prevalent sources of knowledge for the participants' understanding of person-centred care. The title quote of this chapter is from an interview with Maggie, a care worker of many years' experience. Her poignant declaration of unwavering commitment to clients illustrates a profound sense of attachment and dedication underpinning the meaning of person-centred care from a Nurturing Intimacy perspective.

8.2 Overview of Nurturing Intimacy

Members of the group are listed in the table below.

Table 8.1 Members of Nurturing Intimacy

Participant number	Participant name	Job status	Setting
CW001	Eileen	Self-employed care worker	Community
CW006	Maggie	Self-employed care worker	Community
CW007	Faith	Provider-employed care worker	Residential
CW009	Sarah	Provider-employed care worker	Residential
CM002	Steve	Provider-employed manager	Community
CM008	Samantha	Provider-employed manager	Residential

This table shows an even split between domiciliary and residential staff, with three in each setting. Maggie, a community care worker, was highly experienced, with more than 30 years under her belt. There were slightly more workers than managers; small numbers meant no meaningful patterns were identified. Key features of practice for Nurturing Intimacy are illustrated in the diagram below.

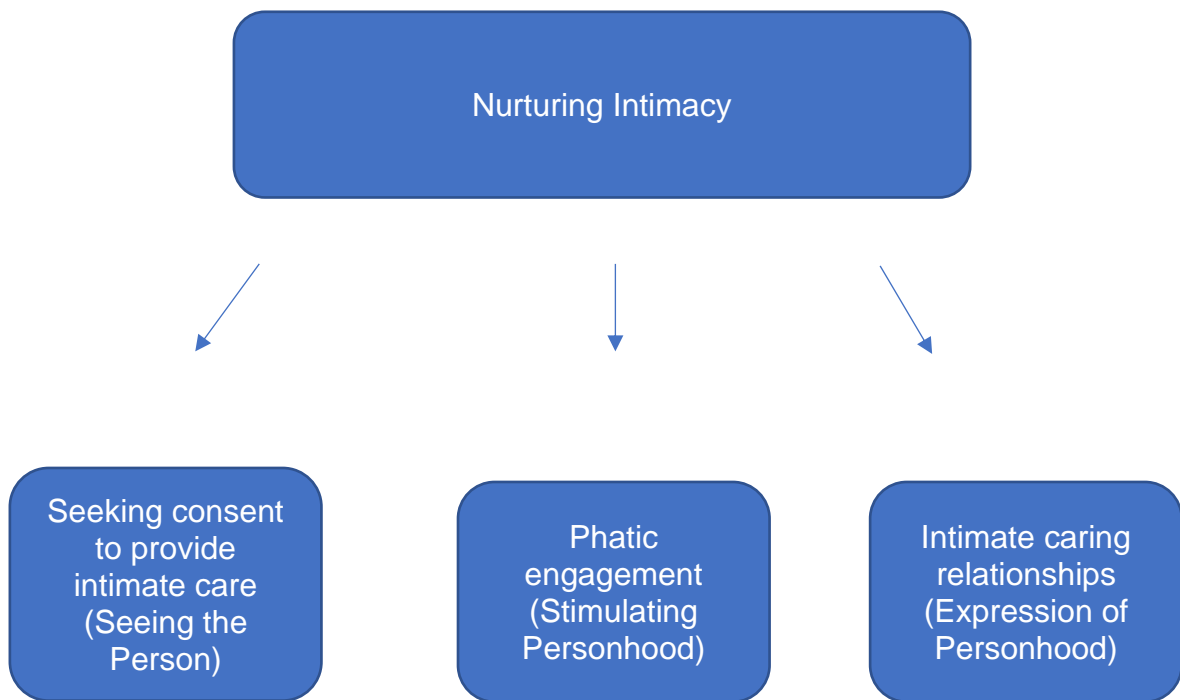


Figure 8.1 Key components of Nurturing Intimacy perspective on person-centred care

Core elements of Nurturing Intimacy were captured in a pen-picture involving Maggie, below.

8.3 Pen picture introducing a Nurturing Intimacy member

Maggie, 65, self-employed community care worker in South West

“I’ve been a carer for 35 years, after starting in auxiliary nursing in the mid-70s. I’ve come from a family where we’ve always helped each other out. I was very close to my grandparents. In terms of my career, I’ve worked for companies and in care homes but I’ve been a self-employed carer for the last ten years.”

Loneliness among older people – that’s a real big thing. A lot of them are lonely, they’re on their own from early in the morning. And unfortunately for some carers, that’s all they are, as carers. Whereas my clients tend to become my friends. Two of my regulars are a couple, husband and wife, I pop in in the morning and sometimes the evening to see they’re all right and they text when they need me. One of my clients, I help her upstairs and into bed, I undress her, wash her, and the next morning she stays in bed all night, and I take her up a cup of tea and her meds, and then she will actually get out of bed and get herself dressed early.

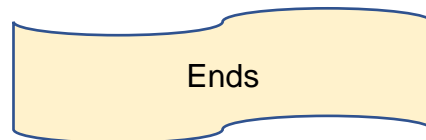
Most of them, especially the elderly, love fruit cake. Or sponge or pasties or scones. I make them at home and take them to clients when I can. You become almost like family.

When it comes to person-centred care, it’s a hard question because I just do it. It’s seeing that all their needs while I’m there are met. And depending on what degree of care they employ me for, it’s everything, you know. Whatever they need, and that’s what I do.

One man in his 90s, Peter, he died only a couple of weeks ago – he was just fantastic. I took him to our local pub and he was such a gentleman. I used to absolutely adore taking him out. He’d come to my house, I’d bring him because he liked talking to men. He would come for a roast meal and a can of bitter with my husband and they’d talk about football. Not because he paid me, I just did it. But Peter was going downhill so quickly recently that he went to bed and didn’t wake up. And that was a good way of dying, if there is a good way.

There was a poem out many years ago called, ‘What do you see, nurses?’ I was given that back in the ‘70s in a local hospital. It’s about remembering older people had a life too and they deserve respect and dignity. I remember seeing that for the first time and it made me cry. Even to this day I still cannot read that without crying. Oh my word. It’s so sad and so impactful.

I've got a good rapport with my clients and I stay for a long time. I stay right until the end. I've laid out many a body, put it that way. And I've never left them anything but looking lovely for whoever's coming in. It's very sad but one good thing is you know they didn't die alone. We come into this world surrounded by joy and a lot of people unfortunately leave it alone. Which is very sad. But for me, my clients, I've always said, you know, 'I'll never leave you.' And I haven't. I'll always stay."



Reflections on Maggie's pen picture

Maggie's pen-picture suggested her understanding of person-centred care was built on deep, underlying respect for older people, believing they were inherently worthy of dignity. Striking a rapport with people appeared to come naturally to her. Consequently, she developed long-lasting friendships with clients. As Maggie said, 'my clients tend to become my friends'.

In fact, Maggie went further—than friendship - her clients became 'almost like family'. The account of interactions with former client Peter was indicative of the familial (or family-like) relationships formed with people she supported. By inviting Peter to her home for dinner, the care worker treated him as a proxy relative. She seemed generous with her culinary skills, offering home-made cakes and pasties to clients. The importance of family values from this participant's perspective was suggested by having been very close to her grandparents as a child.

Maggie suggested her professional approach depended on ‘what degree of care [clients] employ me for’, which seemed very open-ended. More details emerged when Maggie described assisting one person with washing, dressing, and medication – elements of personal care, or, in other words, doing things for the client. References to ‘the elderly’ and mortality implied an acceptance that older clients would become more dependent as ageing progressed. Maggie was ready to provide personal care when people’s needs became more extensive.

Maggie’s reflections on loneliness and isolation in old age demonstrated a strong sense of compassion towards challenges faced by people later in life. Her belief in affording such clients dignity was illustrated through poignant testimony of her end-of-life duties. Maggie’s practice of tending to clients’ bodies and leaving them ‘looking lovely’ was a sanguine account of work many people would find extremely challenging, but indicative of the remarkable depth of commitment to her clients. By developing intimate caring relationships, embodied by emotional warmth, friendship, and expert caring skills, Maggie sought to improve her clients’ well-being.

The following sections will examine some of the assumptions and processes highlighted in this pen picture, underpinning the Nurturing Agency interpretation of person-centred care. Firstly, members sought consent from people to provide intimate care, discussed in the section below.

8.4 Seeing the Person: seeking consent to provide intimate care

Nurturing Intimacy practitioners suggested they often cultivated close relationships with clients. In the beginning of such relationships, boundaries needed to be established and members sought consent to provide intimate care to adult clients. The identification of these boundaries – part of an initial practice

of seeing the person - was central to a Nurturing Intimacy understanding of person-centred care.

Eileen, a community care worker, had developed her own style of consensual care. Her approach involved stimulating dialogue with clients at the start of any caring relationship.

I always make sure that they know, I think that's important to tell them. 'If there's something that you do not like, then please, you know, tell me.' We have, we have to have that communication. It's got to be done, hasn't it. You know, you can't just expect them to accept what you want, you have to ask them.

Eileen, CW001, community care worker

The seeking of consent was framed within a polite request to 'please...tell me' if there was something the client did not like. The importance of seeking consent was indicated by Eileen's comment, 'you have to ask' clients what they wanted. Opening channels of dialogue and willingness to listen appeared among the first steps in gaining a client's consent to provide care, from Eileen's perspective. In another part of the interview she discussed typical interactions with a regular client.

We work well together. You know, I listen to what she tells me. I say to her, would you like this. You know whatever you want me to do I'll do. If you don't want me to do it you must say. We do a lot of talking.

Eileen, CW001, community care worker

This extract was distinguished by posing questions in the form of gentle suggestions, such as '[W]ould you like this?' The request that the client 'must say' if they didn't feel comfortable seemed to represent an attempt to identify initial boundaries of care. The fact that she and her client did 'a lot of talking' implied dialogue was a familiar tool for Eileen in developing consensual connections with clients.

Steve, a community care manager, described the structured way he interacted with clients to identify boundaries of care. For example, he explained the actions he would take assessing the care of Linda, the fictional client.

We would give Linda a call after the first visit to see how it went, and we – this is the office team or whoever did the care plan. We would also call again two weeks later, and in between if necessary but proactively call two weeks later. And the point of two weeks later is to go, ‘Have we got this right? Have we found you a care-giver that is right for you, Linda, is it somebody that you’re stimulated by, somebody that you get on with and you can see that you can build a relationship with?’

Steve, CM002, community care manager

Steve demonstrated a fastidious approach towards confirming a client’s satisfaction with the care service and the person providing it. He described checking in with them at designated intervals as ‘proactively’ communicating, reflecting the pre-emptive style adopted by Eileen in the previous example. The desired goal appeared to be matching clients with suitable care workers to develop intimate caring relationships. This objective was evidenced by the imagined question, ‘Is it...somebody that you get on with and you can see that you can build a relationship with,’ implying such relationships were central to Steve’s understanding of person-centred care.

Similarly, Samantha, stressed the importance of eliciting a person’s views on the level of intimacy required.

Everything that we do...you know, it’s thinking about the relationship between that younger person, that –older man, their - what their views on that might be, whether it’s appropriate, whether they would be better with an older care member if possible, or have a preference of gender, how they like that bath. You know, is it a bath or a bed bath, are we covering them with a towel, how...you know, some people don’t mind, they’re just, you know, there...but for other people that whole process that

even if it's as simple as, you know, having a wash, needs to be, needs to be really person-centred and centred around how they would want that.

Samantha, CM008, residential care manager

Samantha acknowledged some clients may prefer to have straightforward assistance with care tasks and nothing more. However, her interpretation of person-centred care meant staff should attempt to go beyond perfunctorily meeting needs. Samantha seemed concerned with tactfully understanding people's views on intimate care – 'how they would want that'. Her subsequent reference to this style of care being 'person-centred' suggested gaining the client's consent and understanding their values were important to her interpretation of person-centredness.

Interviews with Nurturing Intimacy members contained one exception to the practice of seeking explicit consent. Maggie's interview implied she did not typically ask direct questions of a client. When asked how she might become aware of a client's needs, she said:

It's their ability for what they can do for themselves, some people can't even get out of bed very easily. Well, it's just so easy, I've been doing it for so long, you know almost instinctively what they can and can't do. Very quickly.

Maggie, CW006, community care worker

In this disconfirming case, the account suggested Maggie relied on intuition and experience to understand a client's abilities and vulnerabilities. The idea of knowing 'almost instinctively what they can and can't do' and lack of references to dialogue with clients in her interview suggested Maggie tended to gain consent to provide intimate care tacitly, rather than explicitly.

In spite of this outlier, the weight of practical examples of consent seeking using dialogue suggested this practice was an important facet of person-centred care from a Nurturing Intimacy standpoint. Practitioners also relied on other forms of

communication to stimulate friendships with clients, discussed in the next section.

8.5 Stimulating Personhood: phatic engagement

In Maggie's pen-picture (Section 8.3), loneliness in old age appeared to be a central concern. A Nurturing Intimacy understanding of person-centred care viewed strong relationships as an antidote to this. One of the means by which relationships were developed was phatic engagement: when people talk to one another with the aim of bonding and socialising. There were many instances of this within the data for Nurturing Intimacy practitioners.

Some of the clearest examples of this phenomenon were expressed by Maggie. At one point she recalled mutually enjoyable conversations with a client, a retired nurse in her nineties.

If I do anything she thinks is wrong, she'll tell me. Almost like she's a sister in a hospital, she's so funny. [Laughs] And I have to say, 'All right then. Things have changed now.' 'Well they shouldn't really change, should they, dear.' And bluh-bluh-bluh-bluh-bluh. She's lovely.... Sometimes, she'll tell me, if she's doing things, like, I don't consider proper, in my view, she'll say, 'But dear, you –don't argue with - you don't argue with your patient. You just don't argue.' She somehow forgets she is the client, she's ever the sister. She's lived and breathed it all her life and she's wonderful. She thinks doctors today are just awful. And the district nurses are dreadful!

Maggie, CW006, community care worker

This colourful narrative illustrated a series of communicative acts of giving and listening on Maggie's part. She appeared to give time and patience to allow light-hearted moments and clients' playful sense of humour to emerge. These qualities were reflected in the gentle admonishment to Maggie, 'But dear, you just don't argue' and the recollection that her client was 'ever the sister'. One

could imagine knowing nods exchanged over cups of tea between the two ladies, who (judging by this account) seemed to enjoy mutual camaraderie and respect. The passage suggested careful listening; the participant quoted her client's comments about the healthcare system. Maggie seemed to have strongly affectionate feelings for the woman she described as 'wonderful' and 'so funny'; the lady in turn addressed Maggie as 'dear'. This part of Maggie's speech was punctuated with exclamations, as if the memories were touching and amusing.

Later in the interview, the same participant remarked:

But yeah, my other dementia lady, she's so full of humour and she's an absolute delight.

Maggie, CW006, community care worker

This comment exemplified some of the key themes of the Intimacy group. A feeling of interdependence was reflected in the use of a possessive determiner, 'my' in 'my other dementia lady'. The expression implied a sense of emotional attachment from Maggie towards the client. The glowing tone of the account – 'she's so full of humour and she's an absolute delight' – indicated genuine fondness, implying that, in spite of possible cognitive impairment linked to dementia, her client's personality remained partially or wholly intact. Maggie appeared willing to indulge those soft sides of her client's personality through phatic engagement.

Another member of the Intimacy group, Steve, touched on the issue of phatic engagement in his interview. Although his role did not revolve around one-to-one work with clients, he demonstrated keen awareness of front-line interactions. In this example he spoke warmly about one client-worker pairing in particular.

And [one of the care workers in my team has] been doing this for about two years...I sat with her and I said: 'How – you know, how do you do all that? How do you do a full day's work and then go work for us for another couple of hours, do you not just want to rest and go home?' And she said: 'Well, Steve, it's not like working, I love this client so much it's just like going round to see my gran. We have such a laugh, we have such a lovely time that it really is my social life. So it works really well for me and I love it.'

Steve, CM002, community care manager

The relationship "between worker and client in this account was packed with references to affection and mutual enjoyment. The visits involved 'such a laugh' together and were like the worker's 'social life'. This jovial atmosphere reinforced the idea of phatic engagement between staff and clients, where talking is done for talking's sake. The phrase, 'it's just like going round to see my gran', projected a sense of familial bonding, a theme introduced in Section 8.3, Maggie's pen picture.

In other interviews, participants hinted at engagement with clients without so much detail.

I've got my five...five residents here. And I'm really satisfied that I do give them time, I do know their families, I do know their ins and outs, I do know their likes and dislikes and I do feel that they would come to me if they needed anything.

Faith, CW007, residential care worker

The tone of this account by Faith was more formal than previous extracts. However, there were some linguistic similarities with Maggie's anecdotes. For example, Faith referred to the residents in her care as 'my five residents' in the same affectionate manner as Maggie's phrase, 'my...dementia lady'. Faith positioned herself as a reliable confidant of her residents, available to call on at any hour. She felt she was generous with her availability – 'I'm really satisfied that I do give them time'. (Presumably this was a precious commodity in a busy care home.) The participant also knew the people's families and 'ins and outs'.

While the occurrence of dialogue is not explicitly stated, the description implied that the interviewee prioritised engaging with residents and their families and building relationships.

One participant went further than merely talking to clients, and involved bodily contact in her intimate caring approach.

And the other thing is also not to have, you're not supposed to touch them. You know, if you see somebody walking along and they're glum, you say: 'What's, what's the matter, can I do something?' And they just look at you and you say: 'Do you want a cuddle,' and they say, 'Yes please. Yes please'. So easy. Everybody needs touch. Everybody needs touch. It doesn't have to be suggestive in any way, to hold someone's hand, maybe put an arm round their back. Something like that. That is what I think is important. That for me, is everything.
Eileen, CW001, community care worker

Eileen described these moments of offering 'an arm round their back' or 'a cuddle' with a candid, matter-of-fact tone, as if her tactile approach was an everyday practice. There were reminders of the 'Seeing the Person' stage described in Section 8.4, 'seeking consent', as Eileen made a point of asking if the person would like a cuddle. The phrase, 'if you see somebody walking along', suggested the imaginary scenario might have been taking place in her local community, which suggested her personal values and life experience may have influenced her professional outlook on care. Her reflections that 'everybody needs touch' and tactile engagement being 'everything' were unique in one sense, as other participants did not mention bodily contact as part of their practice. On the other hand, it could be seen as a logical extension of the values of Nurturing Intimacy, where sensual gestures might strengthen an intimate client-professional relationship.

Such deployment of tactile and phatic engagement were distinguishing features of practice when it came to stimulating personhood, from the Nurturing Intimacy

perspective. The third major component of the perspective and hallmark of the approach was the anticipated outcome: intimate caring relationships with clients.

8.6 Expressions of Personhood: intimate caring relationships

Members of Nurturing Intimacy were keen to develop caring relationships with clients embodied by mutual esteem and respect. The Nurturing Intimacy perspective believed strong client-professional relationships were the ultimate expression of personhood, and a vital underlying feature of well-being for older people. The qualities of these relationships were framed in different ways by participants. Some referred to clients as friends or possible friends, others suggested they became like family. For example, Steve, a community care manager, said he encouraged staff to become friends with clients, and outlined his approach when dealing with new client referrals. Firstly (as mentioned in Section 5.3 of Chapter 5), Steve matched clients with workers who had similar interests and personalities. The desired outcome was that the two parties would become friends.

...we believe we want to have time to do all the things that the client wants us to do. But also have time to sit and be with the client and talk to them and find out how they are and what they're thinking about and be their friend. As well as doing all the things we need to be there, for...it makes for a very different form of care and I believe a very person-centred form of care.

Steve, CM002, community care manager

Steve's interest in cultivating strong client-professional relationships was reflected in the discussion of interaction. This account implied strong listening skills on the part of staff, who should attempt to 'talk to them and find out how

they are and what they're thinking about'. Similar themes were visible elsewhere in the interview, in answer to a question about the meaning of person-centred care.

So to us it means that we provide the person or the care-giver to the client that the client really wants. And somebody that they could be really good friends with, like an extension to the family.

Steve, CM002, community care manager

Steve attempted to schedule visits to allow sufficient opportunity for regular interaction between the same two people, in the hope they would become 'really good friends', or even like an extension to the family. The upshot was that this approach would deliver 'a very person-centred form of care', in Steve's view.

Maggie also spoke of becoming 'almost like family' to some clients (see Section 8.3). In another part of the interview, she commented about one person she supported:

She calls me her friend as well as her carer, which I love.

Maggie, CW006, community care worker

Other participants shared this interest in developing friendships with clients. For example:

You're their friend, you're their confidant—, you know, they - you've got their trust. It's everything.

Eileen, CW001, community care worker

Elsewhere, Eileen stated:

I have a bond I think with my clients.

Eileen, CW001, community care worker

The emotive epithets used by Eileen in these extracts – ‘I have a bond’ and ‘you’ve got their trust’, for example - illustrated the apparently robust nature of her relationships with clients. These speech acts also hinted at the preferred outcomes of her Nurturing Intimacy approach. Eileen seemed to view herself as a dependable confidant of people she supported, forming bonds and friendships with them. The phrase used to round off this description, ‘it’s everything’, projected a sense of importance to these relationships in her overall understanding of person-centred care.

Other participants used less emotive descriptions when talking about client-worker relationships. Faith explained:

You can't just go in and just do the job and walk out. It's knowing that person and building up a relationship with them, I feel with my five that I've got, I get on really well with them. They can turn to me for most things if they can't get hold of their families, which at the minute they can't.
Faith, CW007, residential care worker

This participant stopped short of labelling her relationships with clients as ‘friendships’. However, lines such as ‘they can turn to me for most things’ and ‘I get on really well with them’ projected a perception of Faith as a dependable ally. Her reference to clients not being able to get hold of relatives was in the context of COVID-19 restrictions in place within care homes at the time of the interview. The fact that Faith raised this issue suggested client-professional relationships had become more important during the pandemic, as staff tried to fill voids created by the absence of visiting relatives. Another participant from the residential sector, Samantha, appeared to have similar beliefs about developing relationships with older clients. When asked which skills were required to deliver person-centred care, she replied:

The ability to communicate, the ability to listen, the ability to engage with people.

Forming relationships.

Samantha, CM008, residential care manager

These skills – communication, listening, engaging with people - were instrumental to a Nurturing Intimacy perspective of person-centred care. As a senior manager, it was likely these beliefs around relational care would inform Samantha's attitude towards training and recruitment. Elsewhere, Samantha elaborated on her management style:

We've done things like every contact counts, so just reminding staff about, you know, it can be that you just sit and have a conversation with someone for five minutes. Or if you're popping into someone's room to put their laundry away, just stop and have a chat with them. And just, those basic things, like, you know, we call it very different things but down tools at eleven so everyone stopped working at eleven and went and found someone to talk to.

Samantha, CM008, residential care manager

This example illustrated efforts to create opportunities for staff to 'stop and have a chat' with residents and stimulate meaningful conversation in the care home – perhaps to avoid the tendency towards task-focused care. Like Steve, Samantha's interview included examples of using managerial skills to promote strong client-professional relationships within an overall understanding of person-centred care.

These practices could lead to substantive emotional attachments involving the proponents of Nurturing Intimacy, as discussed in the next section.

8.7 Emotional attachments between Nurturing Intimacy members and clients

Members of Nurturing Intimacy referred to people they supported as friends or even extended family members. Participants appeared to develop deep emotional bonds with clients, with feelings of stress becoming exacerbated when clients' health deteriorated. One example was shared by Eileen, who struggled to support a former client with complex health problems.

And then she got shingles. And she was so poorly. And this would be one where I had to get her out of bed, get her onto the commode. Wash her head to foot, because we couldn't get her upstairs. So it was a wash with bowls of water...And we were putting five different creams on her, on her body. And one day, this upsets me. I just felt I hadn't done enough. I'd done everything I was supposed to. And I cried. And you can hear me, I'm getting upset. I cried all the way from her house to my next client. I was so upset. 'Cos I couldn't help her. That is the only problem, I am emotional. That's the biggest problem.

Eileen, CW001, community care worker

As Eileen explained, she became upset when recalling that she 'couldn't help her'. As a result she 'cried all the way from her house to my next client'. Those feelings of emotional anguish seemed genuine, her voice wavering on the telephone at that point during the interview. Eileen's humility and sense of regret were indicative of a profound responsibility she felt towards her clients. She suggested it was a problem that she was 'emotional' as a care worker. Yet in another part of the interview, Eileen appeared to take a different view towards emotional involvement:

We are also told not to get too emotionally attached. And to me, if you are detached, you shouldn't be a carer.

Eileen, CW001, community care worker

In this extract, far from viewing emotional attachment as problematic, Eileen argued strongly against a detached style of caring – a strength of feeling evident in the phrase, 'you shouldn't be a carer'. It was difficult to reconcile these two apparently contradictory statements: on one hand, describing having

strong emotions towards clients as a 'problem', and on the other, suggesting people who behave in a detached manner should not be carers. This uneasy co-existence suggested Eileen's conflicting views about the issue, as she simultaneously said becoming emotionally attached with clients was a problem, while supporting the idea of emotional attachment. Elsewhere, Eileen commented:

Everything shows on my face anyway, so I've been told. I wear what my feelings are on my face. Everybody tells me that. So they know if I'm cross, probably – it's not very often, or if I'm not happy about something it generally shows on my face. I can't help that. That's just me.

Eileen, CW001, community care worker

Eileen's emotions seemed to rise to the surface naturally, according to this extract, regardless of any intentions to suppress them. A contrasting perspective was presented by Faith, a residential care worker. She described her typical reaction when residents passed away.

It's hard, but you're there for them, it's not about you. You know, afterwards you do pull yourself off the floor for five minutes and pull yourself together before you go back into another bedroom and deal with somebody else.

Faith, CW007, residential care worker

Faith admitted it was 'hard' when residents died, adding she took breaks to allow time to deal with her emotions. This attitude hinted at the need to hide one's feelings, in contrast to Eileen's unfiltered emotional responses.

While these extracts have illustrated the emotional pitfalls of forming intimate client-professional relationships, other accounts were resoundingly upbeat and positive. For example, when Maggie was asked about any memorable days spent with clients, she did not hesitate to reminisce.

Oh, many, absolutely many. Peter for example...He would love, he would just love a day out, I took him to [name of town] and went to the pub and he was such a gentleman. Oh, he was just so lovely, and I used to absolutely adore taking Peter out. He was so grateful for everything. And those were magic moments with him. I have a lot of good times with clients because I've stayed with them a long time.
Maggie, CW006, community care worker

Maggie's anecdote was embellished with compliments about this former client, such as 'gentleman' and 'so lovely'. Her voice became animated at this point of the interview; the ardour of phrases such as 'absolutely adore' and 'magic moments' indicating an enjoyment of the relational aspects of her job. Such affectionate epithets appeared to substantiate multiple references to friendship in her transcript, suggesting she became firm friends with clients.

The extracts in this section reflected a gamut of emotions experienced by members of the Intimacy group: from sadness at the death of clients, to feelings of helplessness, to joyful reminiscence. Eileen admitted to wearing her heart on her sleeve; her belief that people who were detached shouldn't work in care was strikingly forthright. In another part of the interview she appeared to downplay this attitude. The wide range of feelings suggested by participants' data projected an emotionally charged side to relationship-based care. Having explored the different facets of Nurturing Intimacy in terms of its major practice components, it is insightful to consider the origins of participants' beliefs and values. Sources of knowledge are discussed next.

8.8 Sources of knowledge of person-centred care for Nurturing Intimacy members

Participants were asked how they came to form interpretations of person-centred care. The most influential source of knowledge within Nurturing Intimacy was life experience; specific numbers are in the table below.

Table 8.2: Sources of knowledge of person-centred care for Nurturing Intimacy

Source of knowledge	Number of participants	Name
Life experience	5	Eileen, Maggie, Faith, Sarah, Steve
Independent study	1	Samantha
Training and development	0	

Five participants cited life experience as an important source of knowledge for their interpretation of person-centred care, and one independent study. Eileen, in the former category, gave this answer:

I think life experience...and that's just something you have to learn. I've seen all too often, I've been out - there's young people out there doing care. They may well be a very good carer but it's awful when you see 'em on their phone. [laughs] Standing outside the bathroom door, you know, well, the last carer didn't come in. I said what do you mean? 'Well they didn't do this.' I said, 'what they didn't wash you?' 'No, they let me do it myself.' They hadn't even asked, you know. You should ask. They say, 'yes please' or 'no thank you'.

Eileen, CW001, community care worker

Eileen appeared to rely on social skills and life values in understanding person-centred care. Common courtesies such as 'please' and 'thank you' and offering assistance to those in need took priority. The criticism from Eileen centred on a lack of communication with clients about intimate care preferences. This observation also highlighted an interest in seeking consent to give intimate care (as discussed in Section 8.4). This consensual approach involved both seeking consent, and, crucially, giving personal care when consent was granted.

Other Nurturing Intimacy members raising life experience as a source of knowledge cited personal values. For some, childhood experiences and family relationships appeared to have had powerful effects. This was apparent for Steve, who had grown up in a care home managed by his mother. Early memories of a homely, caring environment appeared to have shaped his views on person-centred care.

She [my mother] provided really very personal centred care...she was already trying to make it as much of a home for them as possible. She was always trying to make it like home, make it like a big family, we have a large dining room that we used to have everybody sitting together, in, as a communal area, we had a large lounge area for people to sit and talk, and discuss things...So I think that's probably my route to person-centred care, really.

Steve, CM002, community care manager

Steve's account of his mother encouraging clients to congregate in communal areas implied she was trying to create a family-like experience for residents, who would become 'like an extension to the family'. He seemed to have been impressed by this caring environment, which created opportunities for phatic engagement and development of strong interpersonal relationships. As the above extract illustrates, he linked these issues directly with the concept of person-centred care ('that's probably my route to person-centred care'). These points seemed to have influenced Steve's managerial policy, and the offering of longer caring visits to promote strong client-worker relationships. The value of familial ties, stimulated by his mother's relational approach, appeared to have had a lasting imprint on Steve's interpretation of person-centred care.

Another Nurturing Intimacy member, Maggie, pointed to an innate sense of compassion for one another, going back to childhood.

I've come from a family where we've always helped each other out, always. From my grandparents to, you know, all the children when I was younger. It's a natural – well,

I've loved it. It just seems normal.

Maggie, CW006, community care worker

The perception of normality of caring for older people – suggested by Maggie's reference to her grandparents – appeared to have shaped the participant's familial attitude towards person-centred care.

The only participant not included in the 'life experience' category was Samantha, a senior manager in a residential care company. She said she had completed a master's degree in mental health and had studied person-centred theory. Such knowledge was visible in the following extract.

I'm really familiar with Carl Rogers and where it all came from, and the, you know, the theories and the psychology behind it...I've got a whole file on person-centred care.

Samantha, CM008, residential care manager

Given the breadth of academic study and the considerable time and effort she had devoted to studying literature around person-centred care, Samantha was allocated to the 'independent study' group. There were some references in other parts of her interview to her childhood, suggesting she might straddle the categories of both independent study and life experience.

I think my whole life has been spent in the caring role, my mother had mental health problems so I grew up with that. But I guess that's where my passion lies that I would always treat everyone as if they were a family member, and that's what I try and instil in my staff... So my whole life, my entire life, has been in a caring role. So for me, it's nothing different,—Daniel, it's just - what we do. And it's the mum test, isn't it. It's - would I want one of my family to be cared for in those homes, and if I wouldn't, why wouldn't I? What's wrong with them?

Samantha, CM008, residential care manager

This extract reinforced the strong beliefs among the Nurturing Intimacy perspective about the importance of familial relationships. Samantha's formative years had shaped her values as a care professional, just as Steve's account implied his had done. Her experiences as a young carer led to Samantha adopting a golden rule of treating 'everyone as if they were a family member' in professional settings, and she now encouraged her staff to treat clients in this manner. The reference to the 'mum test' was another example of family values permeating Samantha's professional outlook on care. The emotive description of her 'entire life' being spent 'in a caring role' suggested the values she was expressing were deeply entrenched.

None of the participants cited training and development as a knowledge source relating to person-centred care.

Overall, these examples illustrate how Nurturing Intimacy perspectives of person-centred care appear to have formed around a kernel of deep-lying personal values. Members' perceptions were not influenced by official training resources or institutional frameworks, but by family values and homespun ideals of courtesy and compassion.

8.9 Concluding comments

This chapter has presented an in-depth exploration of the third part of the typology of person-centred care, Nurturing Intimacy. Practitioners talked about providing intimate, relational care, with the underlying expectation that professionals would compensate for people's vulnerability and deficiency. For example, Eileen spoke critically of other carers who allowed clients to wash themselves. In this part of the typology, members took pride in the generosity of their care-giving.

In terms of the relational aspects of care, Nurturing Intimacy managers wanted to allow close client-professional relationships to grow: Steve paired carers with clients whom he thought might become friends, while Samantha instructed staff in care homes to sit and talk with residents. Explicit links were drawn by Samantha in Section 8.4 and Steve in Section 8.6 between strong client-professional relationships and person-centred care. This evidence substantiated the belief that relationships were at the heart of person-centred approaches, from a Nurturing Intimacy perspective.

Steve and Samantha's interviews included few instances of emotional attachment, which could be explained by having less one-to-one engagement with clients in their work on account of their role as managers. By contrast, workers viewing person-centred care from a Nurturing Intimacy perspective seemed to have a lot invested. The emotional toll on some participants seemed substantial, as Eileen, and her anguish at being unable to alleviate a client's suffering, suggested. Faith mentioned a time frame of 'five minutes' to pull herself together after the death of a resident. One wonders if the emotional impact of bereavement would last longer than that – perhaps it was evidence of Faith showing a 'stiff upper lip' (although it is true that people deal with loss in different ways).

In cultivating these intimate, giving relationships, professionals in this group seemed braced for the possibility of dependency and decline within the people they supported. Their understanding of person-centred care revolved around supporting clients by offering warmth, company and mutually rewarding friendship.

The final chapter considers the findings of the typology as a whole, and reflects on implications for policy and research.

Chapter 9: **Concluding the interpretive policy analysis on person-centred care**

9.1 Tapping into care professionals' local knowledge of person-centred care

Caring comes from the private world of love, families and friendship, but is now the concern of public spheres of work, organisations, and government (Stone, 2000). The emotional, social, and physical worlds of adults with care needs, their aspirations and well-being, have become intertwined with the professional duties of care workers and managers. Requirements to offer tailor-made care services to these clients were underpinned by policy assumptions noted in Chapter 1. For example, the notion within the Care Act (2014) that individuals were best placed to judge their own well-being. The recommendation for care professionals to promote individuality and independence, as set out in the Diploma programme (Skills for Care, 2016a). And the duty to deliver services for individual users appropriately suited to their needs and preferences (Care Quality Commission, 2014).

The crafting of policies around responsiveness to individual need has been linked to attempts to increase the quality of services (O'Rourke, 2016). Proponents of person-centred practice have highlighted a dazzling array of outcomes it could produce in long-term care. Claims have been made that person-centred care enhances people's autonomy, purpose, and meaning (Donnelly & Macentee, 2016). It could reduce agitation (Chenoweth et al., 2009); increase quality of life (Yasuda & Sakakibara, 2017); promote self-worth (Fetherstonhaugh et al., 2014); and increase satisfaction of care experiences (Wilberforce et al., 2017). Casual observers may be forgiven for thinking any

policy capable of delivering such benefits would be appealing for older people with care and support needs. Yet the provision of such effective, person-centred care relied on robust infrastructure, such as training and development opportunities for staff (Ettelt et al., 2019) and reasonable workloads to facilitate one-to-one working between professionals and clients (Fetherstonhaugh et al., 2014). As noted in Chapter 1, there were no mandatory training requirements for care workers in England, and person-centred care was not featured in the top ten topics for skills development among care staff in England (Skills for Care, 2021d). The reality of employment conditions on the front line meant delivering an idealised version of person-centred care was challenging: prerequisites of high-quality training and supervision, reasonable workloads, and managerial support were rarely, if ever, achieved in their totality (O'Rourke, 2014).

As discussed in Section 1.10 of Chapter 1, policy conceptualisations of person-centred care have contributed to a sense of convolutedness. Bullet-pointed lists of abstract principles linked to individualised practices in workforce standards (Skills for Care, 2015, 2016a) carried an unfortunate likeness to a laundry list of desirable outcomes. Academic studies have added to the confusion, as highlighted in Section 2.6 of Chapter 2. For example, there was a suggestion to ensure every client interaction was imbued with knowledge of the person's values and interests (Fazio et al., 2018). While it may have been a useful recommendation in theory, its proposal appears to have been made without reference to practical implications in the context of front-line care work, with its competing priorities.

This project has embraced these imperfections and occupied a space between the aspirational nature policies and the reality of conditions on the front line. The findings, presented in Chapters 5-8, offer a snapshot of the middle ground where complex, interpretive work underpinning person-centred practice takes place. My interpretive policy analysis has attempted to explore tension between intended and enacted meanings in the policy implementation arena, by

examining dissonance between expectations of policies and the experiences of those tasked with applying them to practice (Yanow, 2000). Interviews with care staff have been used to tap into local knowledge, which aids professionals as they negotiate convoluted policy terrain and interpret ambiguous objectives (Morgan, 2019). Findings showed there was no consensus on the meaning of person-centred care from the perspective of participants. However, instead of attempting to be all things to all people, workers and managers prioritised a few core beliefs and practices carrying meaning for them and the clients they supported. The typology, generated through framework analysis, represents a distillation of these interpretations across three distinct approaches. It suggests professionals shared goals of stimulating client well-being through person-centred care, but tended to emphasise different aspects of well-being in their practice, or nurture different aspects of client personhood. Some participants focused on the agency of older people to make decisions and lead fulfilling lives; others prioritised the mental health of clients. A third category of respondents attempted to nurture clients' personhood by developing intimate caring relationships. Each person's approach appeared to relate to a position within the typology, which represents intersections of beliefs, values, and practices. This recognition of nuance bore some similarity to a comment by Lucinda (see Section 5.7 of Chapter 5), about different approaches to care practice being distinguished by distinctive beliefs and values. It also reflected the idea, introduced at the beginning of Chapter 5, that different professionals brought their own interpretive lenses when making sense of policy (Needham & Glasby, 2014). Indeed, the findings reflect a core principle of interpretivist thinking, about the likelihood of the same phenomenon being interpreted by different actors in different ways (Gilson et al., 2011).

Whereas the Nurturing Agency attitude represented the largest category in terms of members, and most strongly resembled national policy guidelines, the Nurturing Mental Health and Nurturing Intimacy perspectives could be described as alternate depictions of the same concept, person-centred practice. A key finding was some of the more nuanced perspectives occupying these

alternative parts of the typology came from interviews with workers who were self-employed, such as Maggie and Matthew. They worked in less highly regulated settings than care homes and employer-provided community care and brought different skills and experiences to their work. There was a sense of removal from institutional frameworks such as employer-sponsored training programmes. Perhaps this distance enabled the development of different facets of person-centred practice, such as relationship-building and emotional and psychological stimulation. Members with such viewpoints tended to be more sceptical of national policy definitions of person-centred care (see Section 5.6 of Chapter 5). As stated in Section 1.6 of Chapter 1, the national body, Skills for Care did not collect data on personal assistants employed privately by adult clients at the time of writing, nor did they seem to consult this part of the workforce for their views on care practice. This was a surprising oversight, considering that one of the skills council's own reports stated that personal assistants were able to work with people in person-centred ways (Skills for Care, 2021a).

Whether participants' understandings of person-centred care arose from life experience (as seemed to be the case for several self-employed workers), training programmes, or independent study, their perspectives on the topic were no less valid than one another. This chapter attempts to take an overarching view of such insights into the meaning of person-centred care, and will consider the findings against key arguments from policy and theory. It will go on to explore how inferences from the findings could be used to generate new ideas for policy action. Firstly, the different aspects of the typology are compared and contrasted against each other.

9.2 Tacit reasoning and beliefs of person-centred interpretations via three-part typology

The interpretive policy study of meanings ascribed to person-centred care was designed with a 'bottom up' perspective in mind. The agency of front-line professionals to make sense of policy objectives is a crucial element in understanding street-level policy translation (Bevir & Rhodes, 2016). From an interpretivist perspective, this actor-centred research design assumed the social reality of phenomena was constituted from meanings produced by the actors themselves (Blaikie & Priest, 2018). In social policy research, meanings attached by care staff to their work could have significant implications for the quality of care and job satisfaction (Pfefferle & Weinberg, 2008). Furthermore, care workers' voices were frequently absent from debates on the future of policy (Hayes, 2017). Therefore, I felt it important to construct the project around the viewpoints of front-line care professionals. With all of that said, the fullness of meaning of person-centredness was not immediately visible in the initial data analysis. Several participants appeared to adopt a laissez-faire attitude towards person-centred care, as noted in Section 5.8 of Chapter 5. Pithy, generic axioms such as 'it's all about the individual...it's everything that they wish for their life' and 'keeping the client's wants and wishes at the heart of everything I do' projected a phenomenon with an abstract, intangible nature. Meaning seemed to be devolved to the client; the professional's own understanding was obscured. Indeed, the ambiguity of wording resembled exhortations within policy statements, as noted in Chapter 1, such as 'everybody is entitled to self-determination and maximum control and choice' (Lewis, 2007) and people could 'choose the care and support that best enables them to meet their goals and aspirations' (HM Government, 2012, p9).

More insight was generated when analysis shifted to granular level; the presence of outcomes was key to formulating person-centred interpretations in front-line settings. This finding was in keeping with a phenomenological belief about the social world, that meanings become clearer when manifestations of a phenomenon are examined. As (van Manen, 1990) argues, the essence of something could only be understood through study of the particulars as they are encountered in lived experience. Existing literature has pointed to similar

findings; for example, care workers have been shown to define the quality of care through client-related outcomes (Chung, 2013). The typology within the present study builds on those findings by offering a rounded, comprehensive overview of person-centred care, unveiling the tacit reasoning and beliefs of care workers and managers in their conceptual interpretations.

Each typological group was represented by vivid expressions of meaning. The belief within the Nurturing Agency perspective to safeguard people's individual autonomy, regardless of age or disability, was striking. Chapter 7 described the objectives as being to empower a client to exercise decision-making and enable maintenance of physical and mental capacity. In a discussion about choices in Section 7.5, Charlotte made an impassioned defence of her approach, arguing clients would have no quality of life if decisions were made on their behalf. The victories achieved by practitioners at encouraging clients to regain independence became sources of immense pride. For example, Nadia's elation at seeing her client recover enough self-confidence to visit the local community despite mobility problems (see Section 7.7). Meanwhile a charming distillation of the Nurturing Agency approach was seen in an image of shared duties in Section 7.6 of Chapter 7, as Daisy described making the tea while encouraging the client to butter their own bread. Finally, Elena's account (Section 7.5) implied she viewed her role as enabling people to do and enjoy things on their own terms. There was no reference to impairment or deficiency typically associated with old age: the emphasis was on living, not ageing.

The vividness of Nurturing Intimacy was implied by the sensuality of members' attitudes towards stimulating the personhood of clients: the warmth of Eileen's embrace. The smell of Maggie's home-made fruit cake. Laughs and smiles shared by workers and clients, encouraged by Steve's companionship-focused management. And the soothing touch of Faith as she held the hands of residents in their final hours.

The Nurturing Mental Health perspective was striking in the charisma, reflexiveness, and enthusiasm brought by its members to understanding person-centred care. Louise sounded delighted when recalling her efforts to encourage clients to rekindle a love of old hobbies (Section 6.7, Chapter 6). There was a therapeutic approach to activity planning, which appeared to involve a great deal of planning and thinking on the part of Nurturing Mental Health practitioners. Matthew's reflexive attitude was indicated by his psychological assessment abilities, of reading a client's personality and energy (Section 6.6). Matthew even talked about connecting with clients in a spiritual sense (Section 6.5, Chapter 6), which was reminiscent of Louise's talk of 'getting to the root' of a person's happiness (Section 6.6), while using natural charisma and sense of humour to engage with clients. The vividness of Nurturing Mental Health was notable in the depth of psychological and emotional reflection applied by practitioners not only towards their clients, but their own selves as well.

These were some of the distinctive beliefs, values and practices embodied by the three typological groups, which helped bring participants interpretations of person-centred care to life. Some of the viewpoints were in stark contrast to one another; others held some similarity. These comparative aspects of the findings are discussed below.

9.3 Comparing and contrasting meanings of person-centred care within typology

The three typological perspectives attempted to capture different features of beliefs, values and practices relating to person-centred care. They were bound together by a shared interest in nurturing: an active form of engagement with the client's unique qualities. I chose the verb 'to nurture' to illustrate the various caring acts from person-centred perspectives because it connoted

encouragement and appreciation of central aspects of an individual's personhood. The act of nurturing implies a process of judgement of needs and qualities. As Tronto (1998, p17) writes, caring requires know-how and judgement – which can be a complex process – alongside explications of need and appreciation of emotion. This typology of practices, illustrated by three distinctive types of nurturing, represented the everyday, taken-for-granted assumptions among professionals attempting to care for older people in person-centred ways.

Several participants appeared to embody their allocated typological group very strongly. With that said, some interviewees appeared to fall within the margins of different perspectives. For example, Louise talked about her managerial approach in this interview extract:

Everything is always about the person, and finding out about what they can and can't do. And when you've been in healthcare for so long, you will find that if you involve the person and you take your team with you rather than talk down to your team and say, 'Right, this is what we're going to do.' There are times you have to do that, don't get me wrong. But actually if you do a bottom-up approach and involve them, you're more likely to get a positive response.

Louise, CM007, residential care manager

The references to 'involving the person' in conversations with staff and 'finding out about what they can and can't do' were noteworthy. They implied an attempt to recognise the strengths of individual people while encouraging them to become more involved in processes and discussions. These points implied Louise's approach was pertinent to Nurturing Agency, because of that group's interest in promoting empowerment and decision-making. Her account of assisting a client to sew curtains (Section 6.7, Chapter 6) could have been interpreted as a way of developing a client's skills and self-determination, which was more aligned to Nurturing Agency. On balance, however, I decided to allocate Louise to the Mental Health group, because of her strong emphasis on

making people happy and the frequency of extracts relating to therapeutic activities and psychological assessment in her transcript.

Judgements about allocating participants to different parts of the typology were made by examining the weight and prevalence of themes within transcripts on a case-by-case basis, as explained in Section 6.2 of Chapter 6. I believe the typology is a helpful tool in clearly framing the values and perspectives of participants at the time the interviews were conducted. It should be noted the three-part schema is not intended to be a blunt, rigid construct. It is possible that, at some point in future, participants' beliefs and practices may vary and cause them to shift from one allotted group to another. The espousal by Louise of practices across Nurturing Mental Health and Nurturing Agency, as explained in the previous paragraph, implied a sense of fluidity and complexity to conceptual understandings of person-centred care within the data. Therefore, the typology could also be viewed as a kind of continuum, an imaginary construction of values along which care professionals' interpretations of person-centred care can be arrayed (Richardson, 1990). However, ultimately I decided to allocate each participant into a single category within the typology based on my analysis of data revealing the values and perspectives of the individual interviewees. The distribution of themes relating to core principles of each typological group across participants is shown in Figure 6.2 of Chapter 6. This part of the analysis helped guide decisions about allocating participants into the most appropriate category of the three perspectives.

One feature shared by participants across typological groups was interdependence of outcomes, experienced by client-professional dyads. One of the most striking parts of Louise's interview was when she described a joint activity with a client as one of her happiest moments (see Section 6.7 of Chapter 6), because she had seen how much enjoyment the client had experienced at the same time. This indicated a general sense of interdependence of rewards visible in the data among some participants, in relation to their clients. Matthew said he was constantly thinking of ways of enriching a person's life beyond care by organising stimulating activities which

made it a 'really, really interesting job' (Section 6.5 of Chapter 6). A similar interdependence was identified in Nurturing Intimacy attitudes. Steve reported a comment from one of his colleagues, who said they 'loved' visiting one older client, as it was 'just like going round to see my gran' (in Section 8.5 of Chapter 8). Maggie said she loved the fact one of her clients considered her a friend (see Section 8.6), while Faith said she got on 'really well' with 'my five', when referring to residents in her part of the nursing home. This reciprocal nature of feelings between professionals and clients implied an intersubjective quality to the relationships, where staff stimulated emotions within clients, and simultaneously felt similar effects (Watson, 2019, p557).

In other aspects of the typology, there was greater dissonance between core understandings of person-centredness. Chapter 7 argued the objectives of Nurturing Agency were empowering a client to make decisions; relational approaches were considered less important. In her pen picture (Section 7.3), Victoria said she tried to keep 'professional distance' from her clients. Nurturing Agency members talked about involving clients in their care (Section 7.5), implying the exercise of physical and mental capacity on the part of the client – in other words, encouraging people to do more things by themselves. By contrast, the Nurturing Intimacy approach was distinguished by strong client-worker relationships and friendships, in order to stimulate clients' well-being. Maggie said professional relationships with her clients frequently morphed into personal friendships (Section 8.3 of Chapter 8), while Steve encouraged his staff to become friends with clients (Section 8.6). The interpretation of person-centred care from a Nurturing Intimacy perspective implied a culture of generosity: professionals were willing to offer personal care, which in practice meant doing things for the client. By contrast, Nurturing Agency participants positioned themselves in the background, empowering clients to become more self-sufficient and independent. Perhaps the Nurturing Agency perspective prioritised empowerment because they wished to avoid a culture of dependency on professional care and support. There was an inversely proportionate relationship between intimacy and independence, as illustrated in Figure 9.1.

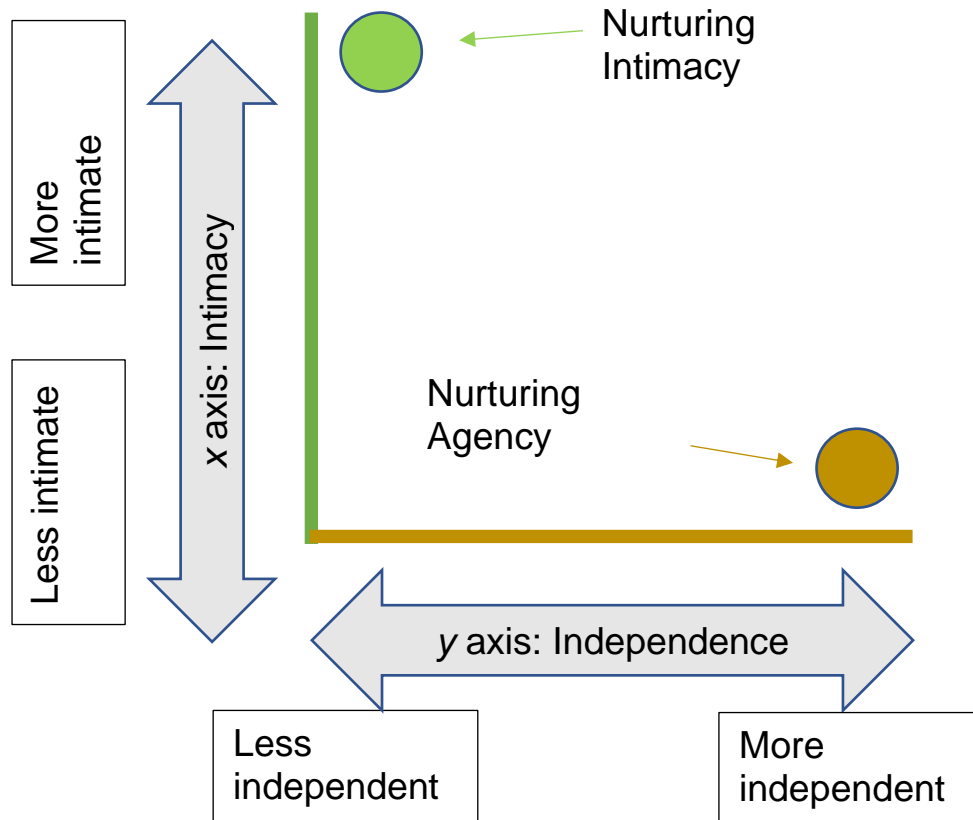


Figure 9.1: Relationship between intimacy and independence for Nurturing Agency and Nurturing Intimacy

Figure 9.1 shows a Nurturing Intimacy perspective with a high position on the x axis, 'intimacy'. This was because practitioners adopting this perspective prioritised close relationships and friendships in their work with clients. There was a low position on the y axis, 'independence', because members tended to perform more care tasks on the person's behalf: intimacy was nurtured by giving and doing things for the person. In contrast, a Nurturing Agency perspective meant participants invited clients to contribute to the care-giving process, empowering them to become more self-sufficient. This meant a high position on the y axis, 'independence'. Care-giving relationships within Nurturing Agency were distinguished by professional distance between clients and

professionals. Therefore this typological group was positioned towards the bottom of the x axis, 'intimacy'.

The distinctions between the different approaches appeared to confirm a finding from literature, noted in Chapter 1, that there was no consensus on the meaning of person-centred care (Håkansson Eklund et al., 2019). Indeed, the challenge of defining the concept lay in the open-ended nature of terms such as 'personhood' and 'person'. There was no true meaning of personalised services, according to Ferguson (2012, p57), any more than there was a true meaning of other values-based concepts such as choice or empowerment. Rather, these were contested ideas on which people and organisations could impose preferred meanings (ibid). The same observation holds for this debate on person-centred care: as indicated by the typology, the concept remains contested, and no single consensus of meaning has been identified. This finding was not surprising, given long-running, contentious debates about the nature of personhood and well-being in sociology. The relationship between the person-centred interpretations revealed by the typology and some of these theoretical arguments are discussed below.

9.4 Relationship between participant interpretations, theory, and policy

The typology may have represented a diverse scope of meanings attached to person-centred care, but the three perspectives were not completely novel in themselves. The core practices and outcomes of all three attitudes have been promoted and discussed within sociological theories on care and support in literature over many years. Furthermore, some aspects of the typology resonated with current policy messages. The strongest correlation with long-term care policy in England was found within Nurturing Agency, which had the highest number of allocated practitioners across the typology, featuring half of

the cohort of interviewees. The hallmarks of practice for this perspective were assessing a person's strengths, while empowering clients to make decisions and become more self-sufficient. Professionals adopting this perspective talked about clients being no different to anyone else, feeling strongly that older people should not be discriminated against. Links between these beliefs and policy guidance emphasising independence and autonomy were noted in Chapter 7. For example, the beliefs reflected person-centred care guidance from the National Institute for Health and Care Excellence (2015), which stressed the importance of care workers focusing on what people could do, not what they could not do.

It was notable that most Nurturing Agency practitioners cited training and development as their main source of knowledge of person-centred care, with the group having the highest proportion of participants citing this category across the typology. Skills for Care said in a report that ongoing learning and development was important for care staff because it helped them to get up to date with current legislation and best practice (Skills for Care, 2022a). The same document (*ibid*) included details of learning outcomes linked to the Care Quality Commission's fundamental standards (CQC 2014). This suggested practitioners taking part in development programmes were likely to be knowledgeable about latest policy guidance on adult care, which could have explained this apparent link between an Agency-focused perspective and staff training. The pattern of sources of knowledge according to different perspectives within the typology is shown in the chart below.

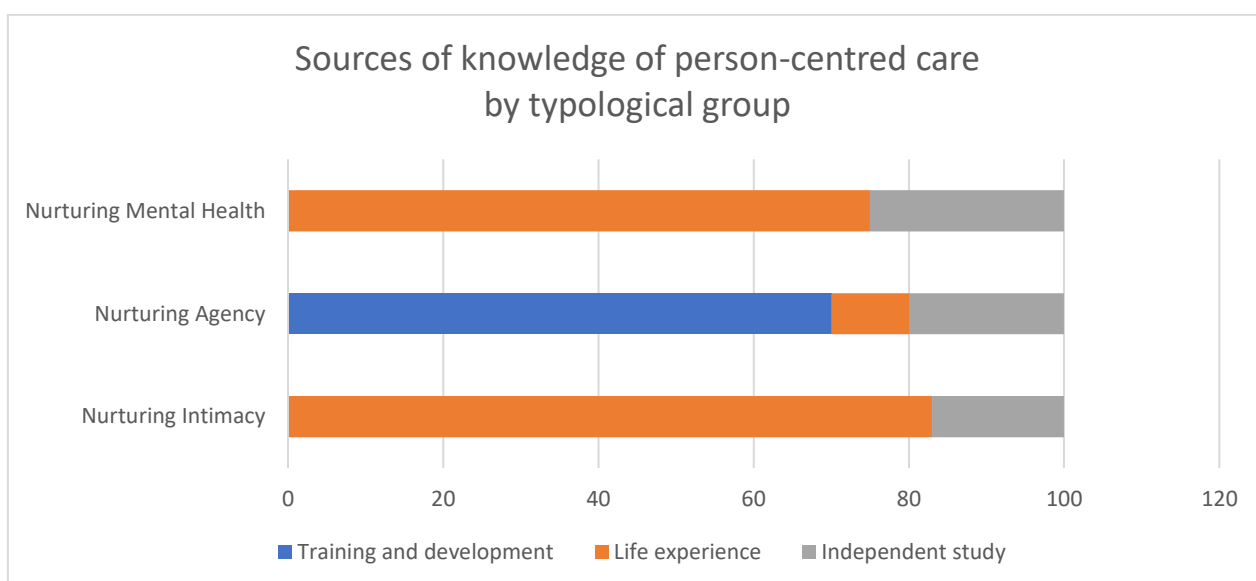


Figure 9.2: Sources of knowledge of person-centred care by typological group

In addition to these similarities between the policy messages and data from participants, one of the Nurturing Agency practitioners (Melissa) said she acquired information about person-centred care from the Care Quality Commission, as seen in Section 7.8 of Chapter 7, and two mentioned studying the Human Rights Act (1998). This legislation reflected key principles of the independent living movement, as it required public authorities to recognise the rights of the individual to freedom of expression and freedom from discrimination (McDonald, 2001). Regarding overlaps with key theorists on caring and therapy, Nurturing Agency reflected some of the core interests of a therapeutic approach inspired by Rogers (see Section 2.2 of Chapter 2). Rogers believed that people could be empowered to pursue their own aspirations and grow as a person, given the correct social and environmental conditions (Murphy et al., 2012). Nurturing Agency practitioners attempted to nurture strengths and capacities within older people in their care, empowering clients to make the most of their lives, on their own terms.

This Agency-focused interpretation of person-centred care resonated with a common viewpoint in debates on individualised practice: that person-centred approaches were necessarily associated with facilitating individual decision-

making. For example, a recent report on the UK adult social care sector (Hayes et al., 2019) examined implications of 'personalisation' for the workforce.

(Although this is a different term to 'person-centred care', the authors referenced the requirement to promote the well-being of individuals in the Care Act (2014) as a relevant policy. This Act has influenced my understanding of person-centred care, suggesting the two concepts, person-centred care and personalisation, are closely related.) The report said:

Workers must understand and embrace the principle of autonomy and self-determination of the individuals they assist and recognise how it fundamentally changes their own role. For example, facilitating service-user directed support might take the form of listening to directions from the individual they are supporting instead of prioritising their own or their employer's beliefs as to how care should be provided. (Hayes et al., 2019, p10)

This interpretation of person-centred care, which emphasised autonomy and self-determination, shared attributes with the Nurturing Agency perspective. However, my thesis proposes a more rounded interpretation of the concept, where the scope of person-centred practice appears broader than models of practice purely focused on autonomy. In addition, the reference to 'employers' in the study by Hayes et al. (ibid) implied the existence of provider organisations, in their role of employers, as possible influences on employees' practice. Some of the participants in my study were employees of provider companies, while others were self-employed, working directly with clients. The interpretations of person-centred care which did not seem to fit the autonomy-focused description by Hayes et al. (2019) were Nurturing Mental Health and Nurturing Intimacy. It was notable that these perspectives featured workers who were self-employed, or had different sources of knowledge to training and development. As Figure 9.2 shows, most Nurturing Mental Health practitioners linked their main source of knowledge regarding person-centred care to life experience, with the same shown for Nurturing Intimacy. This finding implied the existence of more nuanced interpretations of person-centred care in different

parts of the sector, where opportunities for training and supervision were less frequent.

Some aspects of these alternative perspectives towards person-centred care reflected current policy, notably in the Nurturing Intimacy group. Steve, one of the managers adopting a Nurturing Intimacy perspective, suggested he would try to match clients with workers of similar personalities and characteristics. This practice reflected a recommendation by the National Institute for Health and Care Excellence (2015) in its guidance on home care. This stated that providers should ensure a transparent process for 'matching' care workers to people. There was also a recommendation by the government (Department of Health, 2012c) in its response to the Winterbourne View crisis, that employers should recruit staff based on values as well as skills.

Nurturing Intimacy practitioners sought consent to provide intimate care to older people, and attempted to build rapport with clients using phatic engagement. Workers were generous with time and skills, and managers encouraged staff to take time to talk to clients and alleviate loneliness. Some workers expressed great affection towards their clients; the overall objective was to acknowledge that affection and develop intimate caring relationships and friendships. This type of strongly attentive, intimate caring practice reflects a political outlook belonging to feminist theorists, known as an ethic of care (Tronto, 1993). As Tronto (1998) argues, activities constituting care are crucial for human life, as vulnerability plays a central role in the human condition, and caring is seen as a moral imperative. The care offered by members of the Intimacy group to their clients invoked the kind of warm, caring relationships they would participate in either as giver or receiver over a lifetime (ibid). In addition, Faith's attempt to build relationships with her clients' families reflected messages from the Senses framework, a relationship-centred style of dementia care (Ryan et al., 2008), introduced in Chapter 2. This framework called for care professionals to invest time and effort in establishing relationships with people with dementia and their families, to create a sense of security and significance, allowing the parties to

'feel recognized and valued as a person of worth' (ibid, p81). Within the Nurturing Intimacy perspective there were some overlaps with good-practice guidelines, as communication and relationship-building skills were included as a core aspect of a person-centred approach for health and social care workers in national workforce guidance (Skills for Health, 2017).

The remaining, alternative manifestation of person-centred care was Nurturing Mental Health. This set of practices involved studying the mood of the client closely, observing body language and facial expressions. It was marked by a reflexive attitude towards their own behaviour; practitioners talked about using skill and judgement to measure an appropriate tempo to interactions with clients. The emphasis on psychological assessment implied the use of observation and interpersonal skills. Jackie talked about sensing when someone was anxious (Section 6.6, Chapter 6) and Louise discussed reading a person and 'getting to the root' of their happiness. There was symmetry between these features of practice and the theory of personhood developed by Kitwood (1997, p119), and associated requirements for care-givers. For example, the scrutiny of mood and behaviour of older people bore strong similarities with Kitwood's call for 'recognition', where caregivers brought open and unprejudiced attitudes in order to meet 'the person...in his or her uniqueness' (ibid). Care workers and managers adopting a Nurturing Mental Health perspective planned and facilitated activities for clients to stimulate happiness and relaxation. The anecdote from Matthew of flying a kite (Chapter 6) was an example of play, where the caregiver adopted a childlike, creative manner, and stimulation, where the person's senses were stimulated (Kitwood, 1997). Attempts to encourage clients to participate in activities were not always successful, as evidenced by Jackie's example in Section 6.7 of Chapter 6. However, Jackie talked about maintaining the engagement, offering themselves to the older person if they desired that social connection, even if that involved the client simply watching television while the care worker stayed in the same room. This behaviour invoked a suggestion for care-givers to be 'present, in the sense of being psychologically available' (Kitwood, 1997). An anecdote by

Louise in Section 6.6 of Chapter 6 offered a case study of psychologically reading people's behavioural traits, as she talked about the emotional impact of one care worker's behaviour on an older client. Such interpersonal skills demonstrated strong 'interpersonal cognitive complexity', where people have strongly differentiated perceptions of others, and pick up on psychological constructs others exhibit (Medvene et al., 2006).

Steve and Matthew's perspectives, albeit spread across two different typological groups, were indicative of reflexive approaches which seemed constructive towards integrating person-centred thinking into practice. On one hand, Matthew and other practitioners from a Nurturing Mental Health perspective, showed strong self-awareness of their own values and behaviours. On another, Steve attempted to use his management skills to match clients with workers of similar personalities and characteristics. These practices invoked a recommendation by McCormack and McCance (2006), introduced in Chapter 1, that professionals should develop self-awareness and reflect on their own values as part of a person-centred approach.

The Nurturing Agency perspective appeared to have the strongest resonance with current policy guidance. However, perspectives across all three typological groups shared characteristics with different approaches linked to good practice in care and support within existing literature on theory and policy. Alternate attitudes of Nurturing Agency and Nurturing Mental Health had not been developed in a vacuum – aspects of these practices have been advocated by some thinkers for many years. Each perspective of person-centred care held strong validity for the participants, and, seemingly, their clients. Further engagement with different sections of the workforce could generate new insights and enhance understanding of the multi-faceted nature of person-centred care for older people, broadening the scope of debate beyond purely focusing on independence and autonomy.

9.5 Reflections on methodology

In this thesis I have tried to offer a transparent representation of research activities and my analysis of data, which generated the findings. Here, I reflect on methodological issues arising during fieldwork and my evaluation of the overall quality of research.

Interviews with care workers and managers were designed to capture perspectives from people with first-hand experience of interpreting person-centred care. One fundamental issue was the nature of the phenomenon in question. Sometimes meanings are more visible and accessible to researchers through ethnographic observation – as Yanow (2000) argues, local knowledge and meanings are frequently enacted through people's behaviours, actions, and physical objects. However, the same author does not make a hierarchical distinction between the nature of different expressions of meaning or methods of capturing them, in terms of its value for interpretive policy analysis. As stated in Section 3.4 of Chapter 3, interpretive policy analysts are interested in the study of relevant artifacts, which could be found in language, written or spoken by actors, as well as acts, interactions, and physical objects (Yanow, 2003). My project methodology was influenced by a phenomenological outlook which values the common-sense insights and experiences of lay people (Wagenaar, 2011), which could be elicited from interviews with front-line care professionals.

I chose one-to-one interviews because I believed they would encourage interviewees to be more candid in their responses compared to, say, group interviews (Fielding et al., 2008). I ensured participants remained anonymous as part of an ethical research design, to reduce the risk of their being inadvertently identified within the thesis, which may have encouraged people to be speak more openly. The inclusion of a vignette, based on a fictional scenario, helped guide discussion towards examples of person-centred care, encouraging participants to share practical experiences (as noted in Chapter 4).

As for the interview format, it was largely effective for the purposes of the project. I had a hunch that several participants may have felt more comfortable with remote interviews anyway, regardless of the pandemic, given the fast pace of the care sector. In the event, only a handful of interviews were conducted online. For this small number, the video-call format was effective as it helped provide a visual aid to understanding people's arguments, particularly where a participant used hand gestures. It was not always plain sailing, however: one participant attempted to connect online but her internet was disrupted; we decided to abandon that format and switched to telephone instead. On another occasion, technical problems with my recording equipment meant having to repeat the second half of a telephone interview with one participant. (Thankfully she was very understanding and agreed to repeat the same interview questions with me.) Most of the participants opted for the telephone format, perhaps because it was more convenient for them. I felt comfortable with this and the interviews did not suffer from a lack of in-person contact, in my view.

Reflecting on the interview schedule, perhaps some of the questions were too specific. For example, I asked participants to give an example of person-centred care from their own experience. This led to useful answers from some participants, but others found it difficult to answer, perhaps because it felt like they were put on the spot. Asking a more subtle, generic question about an interaction or period of work with a client which went particularly well, would have been more effective. Some participants may have held more examples of this type of interaction at the front of their mind, and I could have teased out examples of person-centredness with probing questions during interview. I learned lessons about appropriate wording of questions. One in particular was long-winded and several participants asked me to repeat it, because they didn't understand it the first time around. This should have been a cue to either drop or revise and clarify the question. In addition, several interviews took place during participants' work schedule, when they may have been keen to return to duty. These indeterminate features, though, were an indication of the nature of interviews as a research activity: they are social interactions between two

people who have not previously met. During the project I have tried to appreciate the complexities of the interaction, rather than trying to control for key aspects of it (Mason, 2018). Overall I was pleased that I and the participants were able to generate a rich, high-quality dataset.

When it came to analysis, the size of the dataset (more than 300 pages of transcripts) made the task feel overwhelming at times. I found the use of NVivo helpful in collating the data and retrieving extracts relating to codes. However, the drawbacks were considerable. As analysis progressed more and more deeply, each new insight from either thematic or framework analysis required revisions to the existing coding schema, which then needed to be retrospectively applied to all previously coded interviews to ensure consistency. As Reiter (2014) noted, with a large dataset one can find oneself trapped in a vicious circle with endless revisions of the schema and applications of new codes, as coding develops. The solution I found was to choose a group of thematic categories, closely aligned to the pertinent research areas of the project while being of a manageable size, and progress from there. Overall, there was no substitute to reading and re-reading verbatim transcripts, to gain a thorough understanding of participants' meanings from their words on the page.

In writing up the findings, I tried to avoid 'artificial coherence', where the author fits the data to a preferred theory based on some superficial similarity, and downplays or ignores cases that might contradict the theory (Thorne & Darbyshire, 2005, p1108). However, the thesis was not a mirror image of what participants told me. I used my own interpretive frame, selecting words and phrases that supported an argument I chose to make, and used rhetorical devices to persuade the reader of the scientific trustworthiness of my writing (Yanow, 2000). As Morse (1994) argues, findings do not 'emerge' from data in the sense of having their own agency. Data may speak for themselves, in some senses, but they are also constructed and selected somehow, and the researcher's perspective and authorial presence should be acknowledged (Mason, 2018). It is the researcher who is driving the interpretation, by deeming

data as relevant, by constructing an argument, and presenting those elements within a final report (Thorne et al., 2004). I tried to be mindful of this and often acknowledged the existence of the researcher's hand by using first-person pronouns, including reflective points within the thesis alluding to some of my thinking at different stages of the research. In writing up I tried to demonstrate an awareness of context, in a theoretical and empirical sense. For example, in Chapter 2 I placed the research topic in context of the general body of scientific knowledge, in order to lay the groundwork for this study (Babbie, 2016, p502). For empirical context, I included information about demographic characteristics of participants, such as age, geographical location, and longevity of experience, in Chapter 5 to allow the reader to visualise the backgrounds and settings in which participants worked. These supplementary materials might have allowed readers to draw inferences or pursue lines of argument that were not well developed in the thesis (Flick, 2014a). To counter possible weaknesses, I have tried to follow a number of quality principles in qualitative research to assure the reader of credibility (Seale et al., 2004). For instance, in this thesis I have explained the rationale for the choice of research design, including analytical strategy (see Chapter 3). In the final presentation of findings, attention was paid to deviant or disconfirming cases (for example, Section 8.4 in Chapter 8), and a comprehensive rather than selective examination of data was included.

The final section of the thesis looks towards using the information acquired from this project in future challenges for policy and research.

9.6 Study limitations

There were several limitations within the study. Methods of recruiting participants had one potential weakness. As explained in Chapter 4 I contacted care professionals via provider companies, and asked managers for support in nominating interviewees among their staff. In this case, the managers were gatekeepers, as they controlled access to the research setting (Bloor & Wood,

2006). This posed a risk that the gatekeepers could have selected participants according to their likelihood of 'toeing the company line', for example, which could have influenced the quality of data collected. The subsequent interviews may have been constrained by an unwillingness among company employees to adopt a critical tone towards their employers or policies (as noted by Kelly, 2012). An alternative could have been to post information about the research project on staff noticeboards in care home companies (as per Scales 2014). Considering the cohort as a whole – not just those employed by organisations – some members may have offered guarded responses, perhaps choosing not to go into detail about clients out of respect for client privacy.

The main data collection method was qualitative interviews, which represent people's experiences existing in a specific place and time. This method was potentially weak because arguments expressed during the fieldwork period may not have been set in stone; the same individuals may have expressed different viewpoints at other times and in other settings. Interviewees may have played up certain aspects of their practice to make themselves, their employers, or their approach seem more favourable. As a small group of care professionals, their various points of view may not have been generalisable across the whole workforce. The remote nature of the interviews meant that some were affected by technical problems. On two occasions during separate telephone interviews the conversation was disrupted by interference on the line. (Subsequently, we were able to complete the interviews as the disruption only lasted a short time.)

Finally, this thesis has argued underlying conceptual meanings of person-centred care are derived from beliefs, values and practices of care work and management, in relation to client outcomes. Representations of such practices and outcomes were extrapolated from qualitative interviews with care professionals. I did not seek to corroborate explicit relationships between practices and outcomes, other than those identified from analysis of the data from the cohort of workers and managers. Instead, the study offers a framework

for understanding professional perceptions of person-centred care in greater depth, and a pathway to further research.

9.7 Policy and research implications

This thesis has examined interpretations of a central objective in today's care sector in England: meeting the sometimes deeply personal needs and preferences of older adults. Structures in the care sector conferred responsibility onto individual care professionals and managers to translate this ambiguous policy goal during everyday practice. This study has tapped into the local reasoning of such actors, helping to re-frame some of the complexities of an ambiguous concept. Access to the world of care workers and managers was gained through the language of participants (Blaikie & Priest, 2018), an emic perspective which favoured accounts of people with first-hand experience of the phenomenon in question. Findings from thematic and framework analysis generated new insights into how the professionals made sense of their work, and this thesis has attempted to show how their interpretations of concepts relate to wider policy frameworks (Maynard-Moody & Musheno, 2015). The in-depth accounts of care work from the cohort implicitly recognise the participants as 'storied beings' (Dahlberg et al., 2009) while generating fresh perspectives on an oft-debated concept.

The findings suggested meanings of person-centred care, as projected by analysis of interview data, were delineated by three distinctive categories. Some professionals emphasised the importance of Nurturing Mental Health, in which psychological assessments and creative use of activities were essential features of person-centred practice. Others adopted a Nurturing Agency perspective, in which they assessed clients' mental and physical capacity with the goal of preserving functioning and independence well into old age. The final

category, Nurturing Intimacy, involved seeking consent to provide intimate care, and developing meaningful friendships with clients.

The heterogenous perspectives expressed within the three-part typology could be explained by participants in the cohort holding differing views of personhood, linked to varying experiences, perspectives, and backgrounds. The discrete interpretations are no more or less valid than one another, even if some, such as Nurturing Intimacy, do not appear to be strongly linked to current workforce policy. One study of person-centred care from an implementation angle considered the barriers of delivering effective services centred around the person receiving care (Barbosa et al., 2017). As discussed in Section 1.8 of Chapter 1, managers consulted by the study authors suggested closed-minded attitudes by front-line workers, resistant to change, were a barrier to implementation. This actor-centred study of person-centred interpretations, guided by principles of interpretive policy analysis, offered an alternative outlook. As Yanow (2000) suggested, the differences of opinion regarding policy meanings in community groups or agencies may not have been simply down to groundless obstinacy on the part of workers. Instead, contending perspectives may have been explained by people with ways of seeing which were epistemologically different (ibid).

One of the goals of interpretive policy research is to show implications of different and conflicting meanings for the implementation of certain policies, as proposed by Yanow (ibid). The author acknowledged that symbolic meanings represented in policy research were intended to offer local truths in a policy issue sense, as opposed to universal truths (ibid). The views of a small sample of care workers and managers who participated in this project cannot lay claim to being representative of such a huge workforce as the care sector in England. However, the research study did not set out to stretch the generalisability of the views of the small number of participants across the whole workforce in England (Green & Thorogood, 2004, p198). Instead, the findings could help further discussion on how care workers and managers approached policy interpretation situations, when working with older people in settings where

person-centred care was often viewed as a fundamental principle. This is what Green and Thorogood (ibid) describe as ‘conceptual generalisability’, where findings do not necessarily allow for generalisability of specifics of beliefs, but instead point towards the existence of local variations which are important for the care sector to recognise. A possible outcome of interpretive policy analysis is to generate new ideas for policy action, emerging from a conversation among multiple voices (Yanow, 2000). Therefore, this thesis concludes with recommendations for policy and research.

The following recommendations build on the findings of the study, and could help forge a pathway for future research and improvements to the adult care workforce. Given its role as the strategic workforce development and planning body for adult social care in England, the policy recommendations are especially pertinent for Skills for Care. This organisation is well-placed to oversee workforce audits at a national level and consult widely on person-centred care in the context of training and development guidance. I will share the findings with Skills for Care and could suggest collaborating on some of the action points together.

Recommendations for policy

- *Workforce development bodies such as Skills for Care should consult care workers and managers for their views on Care Certificate and Diploma guidance on person-centred care, to gain better understanding of how guidance is being interpreted by front-line professionals*

Findings from this recommended consultation should be used to update Care Certificate and Diploma guidance on

- *person-centred care*
- *The scope of Skills for Care workforce audits should be widened to include personal assistants employed by people privately*

Recommendations for research

- *Findings from the three-part typology could be used as the basis for a values-based development tool. This could encourage staff to reflect on personal and professional values and their own views of personhood and well-being, and enable employers to become more cognisant of employees' values and perspectives, for both existing staff and potential recruits.*
- *Further research into personal assistants employed by people privately should be carried out to increase understanding of their distinctive contribution to person-centred care and unique position within the care workforce*

9.8 Conclusion

My thesis provides a theoretical framework to inform practical applications in the workplace which could help employers and care professionals in recruitment, training and development issues in the future. The three-part typology offers fresh insight on interpretations of a ubiquitous concept from the perspective of those tasked with implementing it: front-line care professionals.

The first 'future research' recommendation could see the three distinctive meanings of person-centred care incorporated into a values-based training and development tool. This has the potential to facilitate training and self-reflection among care workers and managers about their own understandings of personhood, in line with the framework proposed by McCormack and McCance (2010 – see Section 2.6, Chapter 2). This framework suggested care staff should commit to understanding their own values base through self-reflection and develop individual approaches to person-centredness. The training and development tool could also be applied in recruitment situations, to enable decision-making among employers seeking information on new recruits' understanding of person-centred care. The other recommendations in both policy and research acknowledge that the definitions of person-centred care in the Care Certificate (Skills for Care, 2015) and Diploma (Skills for Care, 2016a)

lack coherence. As they stand, these policy statements could lead to confusion among front-line staff trying to understand the concept.

In addition, the workforce of personal assistants, or self-employed staff, is likely to be increasingly important in the context of person-centred approaches in future years. There should be more research at a national level into the size and characteristics of the personal assistant workforce. Self-reflection and consideration of personal values have been seen as crucial to person-centred practice within existing literature but so far have not been embedded within employment structures of the care sector; this should change. Care workers, particularly those working outside institutional structures, should be consulted, along with care managers, to improve the definition of person-centred care in workforce guidance. Efforts to engage with different types of workers might encourage more inclusive attitudes among policy-makers towards hard-to-reach staff. Their views have been marginalised in academic and policy literature for too long.

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September 2020

**Invitation to participate in a research project:
“Exploring interpretations of person-centred practice in
long-term care with older people”**

I would like to invite you to participate in a Social Policy research project, about person-centred care and how it is understood and implemented by care workers and managers in older people’s care.

Daniel Lombard, PhD researcher at the University of Bristol, funded by the Economic and Social Research Council +3 Social Sciences programme

Objectives of the research project

The aim of the research is to explore how care workers and managers understand, interpret and experience person-centred care in the course of working with older people. Your participation in the research, as someone with experience of working in residential care, will add tremendous value to my project. Participation in research can empower people and give them a chance to influence changes and debates on future care policy. The University of Bristol has some positive links with social care organisations in the local area and I hope this project will build on those. Your support would be greatly appreciated, and would hopefully benefit the care sector in the future. The findings will be submitted to the University as part of my Social Policy PhD.

Why is the study needed?

Person-centred care has been welcomed by many, because putting the person at the centre of all decisions about their care and support can improve their well-being and offer greater choice and control. However, some people have raised concerns that this approach has been designed with younger adults in mind, and is poorly defined in professional guidance. Therefore it is important to ask people working on the front line of a hugely important sector, caring for some of the most vulnerable people in society, for their views on person-centred care and how it works in practice.

Who is included in the study?

The participants will be care workers and managers working with older people in long-term care in England, either in domiciliary or residential care.

What research participation will involve

Interviews, either in person or on videoconferencing software

I would like to interview care workers and managers to ask about your perceptions and experiences regarding person-centred care. This will take around one hour and will be done either by video-calling on Skype or other software (if you have access to a computer and the internet), or, in cases where this may not be possible, by telephone. In some circumstances the researcher be able to conduct the interview in person, providing COVID-19 precautions are taken. The interviews will be recorded, either by videoconferencing software or an audio recorder.

Analysis

After the interviews are complete, I will transcribe the recordings and analyse people's comments to look for patterns and themes. The main method of analysis is narrative analysis, which looks for the way people use stories to describe and understand their experiences.

The analytical findings will then be written up into a final report, to be submitted to the university, and other articles, to be submitted to academic journals.

Data storage & security

Personal data relating to participants, such as names and contact details, will be saved on electronic files, along with recordings of meetings. These will be encrypted and stored securely at the University of Bristol's Research Data Storage Facility, a controlled-access facility, accessible only to the researcher, for the duration of the project and destroyed less than three months after the end of the study. This is in line with General Data Protection Regulation (GDPR) requirements. The transcripts of interviews will be saved securely and published in the Research Data Repository, managed by the University of Bristol Research Data Service, for 20 years after the completion of the project. This repository allows other researchers interested in studying adult social care to access the data and use it in their studies. The transcripts will be anonymised, that is, they will not include anyone's personal details or information which could be used to identify them.

Confidentiality

People taking part in the research have their names and identities withheld from the thesis and subsequent papers and reports. Pseudonyms or made-up names will be used instead of their real names, in order to protect the identity of vulnerable adults linked to the participant.

I will not disclose participants' personal information to anyone else. However, if I become aware of abuse, bullying or other illegal activity taking place during the research project, I will report this to supervisors at the university and together we will decide what action to take.

Are there any risks to participating?

Care work is a physically and emotionally demanding role, involving close contact with older people who may be frail and vulnerable. Some subjects may be difficult to talk about and if anyone becomes distressed during an interview I will suggest we take a break or finish the interview early.

What if something goes wrong?

In the event of any participants suffering harm during the research they may be entitled to compensation. The University of Bristol holds appropriate public liability insurance.

Has anyone reviewed the study before it starts?

The study proposal is being reviewed by the School for Policy Studies' Ethics Committee at the University of Bristol.

Sharing my findings

I will write several reports based on my findings about person-centred care, including a final report and summary for participants, which I will be happy to share with you after the end of the project. Some of the comments made by participants during the interviews might be quoted in the final report and related articles.

Right to request deletion of data

Participants can withdraw their participation during the data collection and analysis stages of the project if they change their mind and request the deletion of their data. Requests should be made in writing to the researcher (Daniel Lombard). After the research papers have been written it will not be possible to withdraw.

What happens next?

If you would like to participate, please reply to the email or use the email address for the researcher, Daniel Lombard, below.

CONTACT – if you have any questions please contact us using the details below.



d.lombard@bristol.ac.uk



[REDACTED]

This study is supervised by Dr Jon Symonds and Prof Karen West, lecturers at the University of Bristol's social policy department. If you have any comments or complaints about the research, feel free to contact Prof West: karen.west@bristol.ac.uk or 0117 928 9000

If you have a concern about the way we have handled your personal information, you may be able to access support from the following sources.

- i) *The University of Bristol's Data Protection Officer can be contacted on 0117 3941824 or data-protection@bristol.ac.uk*
- ii) *The Information Commissioner's Office has a website - ico.org.uk – and can be contacted on 0303 123 1113.*

Consent form for professionals
“Exploring interpretations of person-centred practice in long-term care with older people”
Daniel Lombard (researcher)
University of Bristol



September 2020

Please read the statements and circle 'yes' or 'no' in the right hand column	
I have read and understood the information sheet	Yes / No
I have been able to ask questions about the research	Yes / No
I understand I can withdraw my participation during the data collection and analysis stage of the project if I change my mind	Yes / No
I understand I have the right to request the deletion of my data from the project at any time, and this request should be made to the researcher in writing	Yes / No
I consent to be interviewed about my work in adult social care, and I consent for this interview to be recorded either by videoconferencing software or an audio recorder	Yes / No
I understand that comments in the interview may be quoted in the final report submitted as part of a PhD thesis, and in other articles and presentations	Yes / No
I understand my name and other identifying details will be withheld from the final report and related articles and all personal data will remain confidential, i.e. it will not be shared with anyone other than the researcher	Yes / No
I understand that transcripts of the interviews and consent forms will be saved securely for 20 years after the thesis has been submitted. Transcripts will be published in the University of Bristol's Research Data Repository, and could be shared with other researchers	Yes / No
I understand that all personal and sensitive data will be encrypted and stored securely on computers at	Yes / No

the University of Bristol and will be destroyed less than three months after the end of the study	
I understand that if the researcher sees anything that causes concern in the data or during visits, someone might have to disclose that information to protect those who could be vulnerable	Yes / No
I appreciate I can contact the University's Data Protection Officer or the Information Commissioner if I have concerns about the way my personal data has been handled during this project	Yes / No
I agree to take part in this study	Yes / No

Printed name: _____

Job title: _____

Organisation: _____

Signed: _____

Date: _____

a

Daniel Lombard, PhD candidate
School for Policy Studies, University
of Bristol

Meanings and interpretations of person-centred care: interview topic schedule



Introduction:

As you are aware, I'm a PhD student at the University of Bristol, and I'm doing a project to learn more about the meaning of person-centred care in the adult care sector, and how it is put into practice with older people. I would like to use your perspectives and experiences so I am grateful for the time you are giving today. I chose this topic because the Department of Health and Social Care is encouraging people in the adult care sector to work in person-centred ways, and I would like to learn more about it from people with first-hand experience. So I will be asking about your experiences of person-centred care in your work, about the people that you work with (both colleagues and people using services), what works and what does not.

I will use this information to write a number of reports and articles, including a PhD thesis to be submitted to the University of Bristol. I will also write a summary of my findings and will share this with you, if you're interested, and others working in the sector. I hope you will find discussing this subject a useful opportunity for reflection on wider issues of practice.

Confidentiality: I will be recording this interview. I will withhold your name and the names of other people, such as clients and colleagues, mentioned in the conversation from the research reports. Your data will be kept securely and confidentially; however if I think someone is at risk of serious abuse, I may have to tell someone. You can have a break or end the interview if you feel the need to do so; feel free to suggest this at any time.

Consent: [while recorder is switched on, read out consent form, ask the participant to confirm they understand and agree to each point]

Questions

Background

Q: Please introduce yourself for the purposes of the recording, tell me your name, job title, and a bit about your professional background.

- How long have you worked in your present company OR how long have you been self employed
- What qualifications do you have
- Have you done the care certificate
- How much experience with older people

Q: Tell me about the kind of people in your care, who you [or your company] support.

Meaning and interpretation, how PCC is delivered in practice

Q: What does person-centred care mean to you, and how is it delivered in practice?

Q: What skills are important in delivering person centred care with older people?

Q: What other things are helpful in delivering person-centred care?

- Is there anything about the person receiving services or their friends/relatives that makes it easier or more difficult in doing person-centred care?
- What about support from or relationships with local authorities/healthcare professionals/community/public?
- What is it about those things that makes them helpful?

Q: Are there any barriers to delivering person-centred care?

Q: What is the relationship between person-centred care and good quality care, is one linked to the other?

Q: The Care Certificate includes person-centred care as one of its core training standards, where professionals are expected to put person-centred values into practice in their day-to-day work. According to the certificate, those values are individuality, independence, privacy, partnership, choice, dignity, and respect. Do you agree with this as an accurate description?

Example of PCC

Q: Thinking about a particular client, can you tell me how you or a colleague gave them care on a particular day or over a period of time, that you thought was person centred.

Emotional response to PCC

Q: How do you feel when you know the care you have given is person-centred

- How do people receiving PCC feel?
- How did their needs and preferences become known to you/your colleague?
- How did you/your colleague know the support was person-centred?
- How do you or your colleague communicate with people?

COVID-19 and PCC

Q: Has your or your team's work changed since the start of the COVID-19 outbreak?

Q: How has COVID-19 affected your or your team's approach to person-centred care?

Q: What impact has COVID-19 had on you/your team personally?

Training and experience

Q: Is there anything in your personal training or experience that's helped you to understand PCC?

Q: Have you referred to any sort of literature to gain a better understanding of PCC?

Vignette

i) For staff primarily working in home care:

Linda is eighty-five, lives alone in a house on the outskirts of town. She has had dementia for five years and recently her memory began deteriorating more rapidly. For example, she sometimes forgets where her clothes are kept. Linda walks with a frame due to arthritis and dizziness. She has two grown-up sons who live far away and don't want to expose Linda to the risk of COVID so don't often visit but stay in touch by Skype.

You don't know much about Linda as a person other than she doesn't like tea and enjoys fresh air and gardening, and has been on her own since her husband passed away ten years ago. If you were supporting her with personal care how would you make it person-centred? What would be the first things you did?

Follow-up questions

- *How would you approach supporting Linda if you didn't have to worry about time and resources?*
- *Has your approach to these kinds of situations been changed since the COVID pandemic?*

ii) For staff working in residential care:

Linda is eighty-five, until last year she lived on her own in the community, and has dementia. When her memory started deteriorating more rapidly, she moved to a care home. Memory loss has affected her in different ways, for example she sometimes forgets where her clothes are kept. Linda walks with a frame due to arthritis and dizziness. She has two grown-up sons but they live far away and don't want to expose Linda to the risk of COVID infection so haven't been able to visit much this year and keep in touch by Skype.

You don't know much about Linda as a person other than she doesn't like tea and enjoys fresh air and gardening, and lived on her own for several years after her husband passed away. How would you make the time with Linda person-centred? What would be the first things you did?

Follow-up questions

- *How would you approach supporting Linda if you didn't have to worry about time and resources?*
- *How has your approach to these kinds of situations been changed since the COVID pandemic?*

Q: Is there anything else you would like to mention that we have not already covered?