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**Stories of Stabilisation:
Creating, Implementing and Resisting
the National Care Homes Contract in
Scotland**

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DECLARATION

August 29, 2014

I declare that, except otherwise indicated, this thesis is entirely my own work, and that no part of it has been submitted for any other degree or professional qualification.

Catherine-Rose Stocks-Rankin

ABSTRACT

In Scotland, as in many other welfare states, the organisation of care homes for older people takes place in a highly contested space where debates about demographics, limited financing and changing expectations of the state compete with questions about choice, rights, equality and models of care. These services intersect the formal boundaries of the public and private sectors as well as the lines between public and private life.

The production of care home services crosses several policy spheres, including local governments, the devolved Scottish administration and the UK government and includes numerous organisational bodies, such as care home providers, the care regulator and the voluntary sector. At the centre of this intersection lies the work of contracting and the production of a national framework agreement for care home services in Scotland called the National Care Homes Contract (NCHC). This contract is both the bridge between the public and private sector and a formalised link between the individual and the institution.

In this thesis, I depict the NCHC document as an artefact which links these spheres and the work of contracting as the practice of maintaining that relationship. I take up the concept of boundary objects and suggest that the NCHC functions as a bridge between multiple fields of practice and is a useful tool for understanding the competing perspectives of people who plan and deliver care home services in Scotland. In this thesis, I reveal the different, and at times competing, perspectives which surround care home services for older people and the stabilising work that is undertaken to manage these differences.

This research utilises an interpretive approach to examine the creation and ongoing implementation of the NCHC. Fieldwork for this research was conducted over 12 months and includes interviews with local authority planners and contract managers as well as care home owners and managers from the independent and third sector, each of whom do particular kinds of work to create, implement and use the text. A textual analysis of the framework agreement is also used to support this research.

I examine the work of making, re-making and using the NCHC at three levels: national policy actors, local government contract managers, and managers of local care homes.

Each group undertakes a kind of policy work: first to create the NCHC, then to implement it in local jurisdictions and finally to use it within local service delivery. Stabilising work takes three primary forms: text work designed to stabilise meaning, relational work designed to translate meaning across boundaries of practice, and ethical work, a value-based emotional work that underpins the first two kinds of everyday labour. I suggest that this work is first and foremost driven by a need to stabilise the care home sector and that it is deliberative in nature and conflict ridden such that the use of the contract in practice is often resisted.

In working to stabilise this system, the values of this work come into conflict – triggering both caring and resistance responses within the sector. In giving an account of stabilisation, I provide a micro-sociology of the meaning making, relationship-building and conflict which underpins policy work. I draw conclusions from this about the discretion of policy actors at all levels of the system, the rational-technical and emotional nature of their work, and the unexpectedly deliberative policy space of contracting in Scotland.

SUMMARY

This is a story about conflict and negotiation. In this thesis, I investigate the way a policy — designed to improve services for older people — was created at a national level, implemented by local governments and used in social care organisations in Scotland. Unusually, this policy document is a contract. Care homes in Scotland are organised through the National Care Homes Contract. It acts as an agreement between all 32 councils and most of the care homes in the country.

The contract creates a standard price for services as well as a standard expectation of the kind of care that should be provided. I suggest that this relationship is often full of conflict, but that people in the sector work hard to negotiate these tensions — because within that conflict and negotiation is interdependence. In this research, I interviewed people who manage care homes, local government employees who plan and maintain the relationship with the care home sector and people involved in the national policy to create a contract for care home services.

At present, the care homes sector in Scotland relies on interdependencies — between the private sector and the council, between social work and the health sector, between paid carers and family members, between people accessing these services and those who are paid to deliver them. This thesis gives some insight into 'how' those interdependent relationships are created, maintained — and resisted — within the organisation of the system itself.

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This thesis is dedicated to my grandfather, Donald Rankin, who would have been so proud to see this come together as it has. He is at the heart of this work — his work ethic is my inspiration and our shared experience of his care is at the centre of my passion for improving support for older people. Beyond my grandfather's inspiration, this project would not have been possible without four friends and feminists: Dr. Charity McAdams, Dr. Ellen Stewart, Dr. Sheryl-Ann Simpson and Dr. Katherine Smith, who I thank for their endless generosity and solidarity.

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BEGINNING WITH AN EVERYDAY 'PROBLEMATIC'

Dorothy Smith suggests that research should be driven by an 'everyday' problem experienced by people in their day-to-day living (Smith 1988). She advocates a move away from theory-driven examinations of the social world and proposes an approach to research that is rooted in the real world. In undertaking this research, I was interested in exploring the everyday technical-bureaucratic work that underpins the organisation and delivery of care services. This focus on the day-to-day activities was driven by my own work in the Canadian care sector. In reflecting on the 'everyday problematic' which began this research, I begin with my experience as a practitioner and the values that drive my research. Making the invisible visible is the foremost driving force behind this project. It's a common position for feminist researchers like Smith who strove to make the work of marginalised and invisible groups visible within research and, in turn, attempted to transform the research process so that local, everyday, knowledge could be included and valued.

In my case, this drive to make explicit that which tends to be implicit can be rooted in my experience as both a care worker and a 'cog in the machine' within the Canadian care sector. In the early 2000s, I worked for an organisation called the Toronto Community Care Access Centre (CCAC) which is responsible for publicly funded community care in the city. Prior to that job, I had worked as a part-time personal support worker. The work I did as a 'care worker' was hands-on. I developed a relationship with the person who needed my support and saw the impacts of my work. In contrast, the job with the Toronto CCAC required me to do administrative work to 'order' (purchase) services for someone who I would never meet. I worked for the 'Admitting and Health Records Team'. As part of this role, I read people's medical history and added their details to our system of patient records. I worked to ensure they received the specific support they had requested, for example: 'a Portuguese speaking nurse for the early am (7-8am) if possible'.

When ‘ordering’ services, I re-typed their ‘client’ information into a web-based system and waited until one of the contracted providers in the area accepted my request. This was a business transaction, though I knew little about that process at the time — much of it depended on my own willingness to ensure that the specific details of the patient’s request were met. If I could get a nurse for the early morning but she didn’t speak Portuguese, ‘should I ‘accept’ or ‘reject’ the provider based on this limitation? What should I do if a Portuguese-speaking nurse wasn’t available?

Doing this work enlightened me to the administrative labour which goes into facilitating the kind of work I used to do as a care assistant. Behind the activities of care, there was other work being done. Some of this work supported the care activities — and some of it didn’t, but our efforts within this system had an impact — though I suspected that most of that was only visible to us and a privileged few who knew about our team and the work we did. Certainly, the lady who needed the Portuguese-speaking nurse was unlikely to know that I existed or had ensured that her request was met.

My knowledge of the care system in Ontario grew exponentially over this period. I learned about the different kinds of care providers, the work they would (and wouldn’t) do, and the amount of publicly-funded care one could expect — 14 hours a week of support was an uncommon luxury. My experience of this job was also a highly emotional one. I found it difficult to work within the rigid and commercialised system of care at the CCAC where people became ‘clients’ and the labour which I undertook to ‘get it right’ for that person was invisible — not only to them, but to the organisation as a whole.

The Admitting and Health Records Team was at the bottom of the CCAC’s organisational hierarchy. Others in the organisation worked more directly with people who accessed support — doing assessments and managing that person’s care journey. These employees were nurses or occupational therapists. Most of my team had no such training and so we were siloed in an administrative role with no direct link to the ‘clients’. We were said to do ‘data entry’, and the requirements for the job suggested that there was very little expectation that we use our own discretion to complete our tasks. Most of my colleagues had a high-school diploma and very little post-secondary education. As such, we were first on the chopping block when it came to organisational shifts and least likely to receive praise for the work we did — it wasn’t very ‘hard’ work after all.

This 'data entry' conflicted with my experience of the job. My sense was that we were, in fact, the hub of the organisation. We were responsible for 'admitting' the vast majority of ongoing service users to the care 'system' and managed their legibility within it. We were advocates for their needs and repositories for confidential information. We were also the commercial hub of the organisation and collected and managed as much data on the contracted providers as we did on service users. More than that, the people I worked with had vast institutional knowledge of the care sector, including the providers and hospitals, as well as the inter-workings of CCAC itself — not to mention a robust knowledge of medical terminology which had been picked up over the years of reading and transcribing medical reports. This wasn't just data entry. If anything, it was much closer to the feeling I had when I worked as a care worker. The sense of responsibility was similar — if less acute.

People cared about the 'clients' that came across their desk. They worked hard to ensure that their requests were met and the confidentiality and anonymity protected. They stayed overtime to ensure the people received their service. They checked in on their day off to make sure that work carried out the previous evening would be picked up the next day. This isn't to say that we weren't also a dysfunctional group. The stress of this work was high at times and compounded by its invisibility to both our colleagues and the people who we helped to support. But it was work — emotional, technical, bureaucratic work — and it helped people, invisibly and without praise or encouragement, I think it helped.

I share these reflections here to make the experiences which underpin my values and approach visible to you, the reader. Throughout this thesis, I endeavour to make explicit the work I've done to produce this artefact of my research. It is as much a product of me — my interests and experiences — as it is of the people I spoke to in the field.

1. INTRODUCTION

In Scotland, as in many other welfare states, care homes for older people takes place in a highly contested space. There are ongoing debates about demographics (Gee & Gutman 2000), limited financing (Bowes 2007) and changing expectations of the state (Ungerson 1990) compete with questions about choice (Knapp et al. 2001), rights (Walker 1982), equality (Lewis 2001; Glendinning 2007) models of care (Townsend 1962; Fine & Glendinning 2005; Armstrong et al. 2009) and markets (Harrington et al. 2001; Holden 2002). These services intersect the formal boundaries of the public and private sectors as well as the lines between public and private life. The production of care home services crosses several policy spheres, including local governments, the devolved Scottish administration and the UK government and includes numerous organisational bodies, such as care home providers, the care regulator and the voluntary sector (Scottish Executive 2007; Midlothian Council 2011; Barchester Healthcare 2014; CCPS 2014; UK Parliament 2014).

At the centre of this intersection lies the work of contracting. A contract for care home services is both the bridge between the public and private sector and a formalised link between the individual and the institution. The contract, as an artefact, links these spheres while the work of contracting is the practice of maintaining that relationship. As a boundary object (Star & Griesemer 1989; Bowker & Star 1999; Star 2010) between multiple fields of practice, the contract provides an useful window into the competing perspectives of people who plan and deliver care home services in Scotland. In so doing, it reveals the ways in which different, and at times competing, perspectives are negotiated and whether certain needs, knowledge or practice are privileged in this process.

I consider the practice of contracting for care home services in Scotland to be the primary vehicle for the production and stabilisation of this care system. I use the term production to refer to the ongoing creation of the system that provides care to older people in residential settings. For example, the day-to-day activities of financing, assessment, quality control, admitting procedures, and so on, which are carried out by local governments and care homes to ensure that people in need of residential support can access that service. By stabilisation, I mean the ongoing work that the people — and the

contract document — do to maintain their relationship to one another. I depict the care home system as a product of interdependent relationships and effort. It is the story of that interdependent labour which I tell in this thesis.

In this introductory chapter, I outline the field of study for this research: contracting for care homes for older people and the national framework agreement that facilitates that system, called the National Care Homes Contract (NCHC). This is followed by an overview of the care homes system in Scotland, highlighting key features of the sector as well as some of the strategic actors involved in its design and delivery. Across these two sections, I emphasis my interpretive approach to the study of policymaking and welfare systems. Throughout this thesis, I pay particular attention to the people who work to provide care, their networked activities, and the tools they use to support that work.

THE CASE: CONTRACTING FOR CARE HOMES IN SCOTLAND

Care homes, according to the Organisation for Economic Co-Operation and Development (OECD) are places which provide “basic activities of daily living over an extended period of time. Such activities include bathing, dressing, eating, getting in and out of bed or chair, moving around and using the bathroom, often in combination with rehabilitation and basic medical services” (OECD 2005, p.10). The UK’s definition of care homes echoes that of the OECD. According to the Care Standards Act 2000, a care home is any place which “provides accommodation together with nursing or personal care for any person who is or has been ill (including mental disorder), is disabled or infirm, or who has a past or present dependence on drugs or alcohol” (Section 3(1)(2)(3)).

But what are care homes really? They are residences: 32, 888 people live in Scottish Care Homes (ISD Scotland 2013). They are workplaces: 56, 940 people work in care homes in Scotland (Care Commission 2009). They are hospices: just under a third of residents die every year and the average length of stay is three years (Bebbington et al. 2000). They are health care facilities: 78% of residents had at least one form of mental impairment and 71% were incontinent (Bowman et al. 2004). They are also commercial entities: 86% of care homes are owned/operated by the private sector (75% are run for-profit, and 11% not-for-profit) (Laing & Buisson 2014).

All this suggests that care homes are complex spaces where the needs of different people operate in contest. As a result, the potential for conflict is incredibly high. This attribute is evidenced by the conflict over wages and occupational safety between workers and employers (Daly et al. 2011; Ungerson 2004; Yeates 2009). Or the negotiations between care home owners and local authority purchasers over the cost of service provision (Timmins & O'Doherty 2008). Similarly, there has been extensive documentation of abuse in care homes, from worker to resident and vice versa (O'Keeffe et al. 2007; Cooper et al. 2008). Moreover, care homes operate in a mixed-market economy in which they compete for clients and public sector financial support (Holden 2002; Hudson 1992; Randall & Williams 2006).

These conflicts often lead policy makers and analysts to characterise social care and, residential care in particular, as a failure (Griffiths 1988; The Royal Commission on Long-Term Care 1999; Office of Fair Trading 2005; Wanless 2006). A number of explanations for this failure have been suggested, including the institutional character of care homes (Townsend 1962), the erosion of resident identity and individuality in the regulative processes around care homes (Kerrison 2007) and commercialisation of care homes services (Pollock 2004). Others in this field have suggested that the prevalence of for-profit chain ownership (Harrington et al. 2001), the low pay and status of care workers (Armstrong et al. 2009; Daly et al. 2011), the model of financing (Bowes 2007) or the regulatory framework are the root cause of the problem (Harrington & Carrillo 1999).

Outwith academic discourse, the practical realities of care homes failure have been the concern of families, carers and staff, as well as commissioners, contract managers, regulators and policy makers in both Scotland and the rest of the UK. Failures on a large organisational scale have been discussed in the public domain of late, most notably the 2011 bankruptcy of Southern Cross PLC, the largest care home operator in the UK. The very public closure of 90 homes in Scotland, and 752 homes across the UK, was a feature of the national press for several months in advance of their bankruptcy (Anon 2011c; Mundy 2011). It was also the subject of a legislative inquiry from the Scottish Government's Health and Sport Committee (Brown 2012). While national policy makers were debating the closure of Southern Cross in May 2011, local councillors and police in Edinburgh were investigating the deaths of two residents in the Elsie Inglis care home in June that same year (Anon 2011a; Anon 2012). This home, owned by Peacock-Medicare

PLC, was the subject of an investigation by the care regulator in Scotland prior to closure. The crisis that led to this closure was listed, along with the Southern Cross closures, as the central motivation for the legislative review by the Health and Sport Committee.

These are system failures of the kind that precipitate the removal of residents, the loss of jobs and wages, the potential for criminal charges and policy debates about how to manage the possible relocation of 40,000 residents. This is the context in which I situate this research. I suggest that care homes in Scotland operate at a nexus point between the state and market, a hospital and a home, informal and paid care. Further, I suggest that the dynamics of these relationships can have acute, and sometimes fatal, impacts on the people who live within them. The thesis I present is an account of that instability and the work that people do in the everyday to counter it.

The National Care Homes Contract (NCHC) is the most recent Scottish response to these debates. It is this document, and the practices which surround it, that I have elected to study. Contracting for care homes in Scotland is depicted as a tool which local governments deploy to delineate their shared responsibilities with the private, not-for-profit and for-profit, care homes in the sector. The NCHC is unique in the UK as a national framework agreement which formalises the conditions for all private sector care home provision in Scotland. This agreement brings all 32 local authorities and approximately 780 private sector providers into an on-going relationship with one another.

SOCIAL CARE IN SCOTLAND

Since devolution, in 1998, there has been a range of scholarship on the divergence of the Scottish welfare system, most notably the Scottish health system from other models of the NHS in devolved nations (see Greer 2004b; Greer 2005). Very little scholarship exists which explores the differences between the Scottish social care system and its English, Welsh or Northern Irish counterparts. Even after the introduction of the flagship policy on free personal and nursing care in Scotland, there has been very little research on how Scottish social care might diverge or converge with other systems in the UK (see Bowes & Bell 2006; Bowes 2007). This research adds to that conversation, presenting a distinctly Scottish case in the investigation of a national framework agreement as the primary organising device for care homes for older people.

Social Care services, and residential care services in particular, are set to undergo a period of transformation in Scotland. The Reshaping Care for Older People agenda, established by the Scottish Government in 2011, articulated a ten-year strategy to de-institutionalise care (COSLA et al. 2011). As part of this strategy, a short-term budget, called the Change Fund, was created to promote creative strategies for improving and expanding community-based care. Despite this targeted influx of funds, the current budget projects include a substantial decrease in funds for social services in Scotland. While the Scottish Government has been careful to indicate that the scale of these budget reductions is significantly less than those carried out in England (Scottish Government 2010a), there is a sense that the burden of meeting these new budgetary targets has been placed on Social Services Departments, and social care services in particular (Unison 2010).

Since devolution, Scotland's approach to social care has set itself apart from UK policy. By introducing free personal and nursing care to its residents (Community Care and Health (Scotland) Act 2002), the Scottish government was the only member of the UK to adopt the central recommendation of the Royal Commission on Long-Term Care (1999). Unlike England, Wales and Northern Ireland, the Scottish Government is the only devolved country to provide and fund at least a portion of its social care on the basis of need rather than means (Bowes & Bell 2006). In contrast, the other members of the UK continue to require evidence of low-income status before service users can qualify for state support for personal care. There were renewed debates about the feasibility of this policy in the spring of 2010. Tighter budgets and an ageing population were used as a rationale for reductions in the entitlement (Puttick 2010). Interestingly, the Scottish government has renewed its commitment to this policy (The Scottish Parliament 2010). This policy often acts as symbolic representation of the ideological differences between Scotland and other devolved members of the UK.

In order to contextualise the following discussion of social care in Scotland, there are two attributes that are worth highlighting. First, local governments have a legislative duty to ensure care is provided to their local populations. Under section 12a of The Social Work (Scotland) Act (1968), local governments have a duty of care for the assessment and arrangement of social care services for anyone who meets the government's eligibility

criteria. This duty was updated under the Community Care Act (1990), which states that these assessments should be made on the basis of need rather than availability of support.

Second, care home services in Scotland operate as a managed market. This means that the market is highly regulated and characterised by a significant level of state subsidy (Randall & Williams 2006; Randall 2008). Across the UK, the bulk of care home services are provided by the private sector. Currently, 86% of care homes in Scotland are privately owned and operated and that configuration of the market has remained relatively static (Laing & Buisson 2014). The for-profit sector maintains control of approximately 70-75% of all care homes while the public and not-for-profit sector have a nearly equal share of the remaining care homes/places. There are currently 38, 508 places in care homes in Scotland. Scotland offers more generous provision of care home spaces per capita compared with the UK as a whole. A look at trends over time reveals a relatively static sector with a high-level of for-profit ownership. Very little has changed over the last fifteen years with the exception of a small contraction in the number of care homes and care home places.

This straightforward account belies some of the more complex interdependencies that underpin the organisation of care home services, and social care more broadly. The legislative duty might reside with local governments, but there are others within the social care field which bear a responsibility for the delivery of care services. For example, the Care Inspectorate is the Scottish regulator for care services. All providers of a care service must be registered with the Care Inspectorate (The Care Inspectorate 2013). Services are then regulated through a variety of methods, including self-reporting and inspection. Likewise, the social care workforce who provide support in these institution, have a professional responsibility for care (SSSC 2014).

There are also other kinds of strategic guidance within the social care sector. Notably, the Convention of Scottish Local Authorities (COSLA) works with the Scottish Government to produce the Single Outcome Agreements which are intended to support local planning and partnership working (Scottish Government 2007; COSLA & Scottish Government 2008). A variety of national bodies, like Age Concern and Alzheimer Scotland also play a role in providing guidance on the organisation of social care and the strategic direction of services. For example, Alzheimer Scotland has fed into the 2010 and 2013 national

strategies on dementia (Scottish Government 2010c). Representative bodies such as the Coalition of Care and Support Providers in Scotland and Scottish Care also play a significant role in the social care sector, advising local and national strategy around the organisation of care for older people (Scottish Care 2014). The role of Scottish Care, CCPS and COSLA is particularly significant for the production of the annual NCHC document as they are the key policy actors responsible for its design and negotiation.

In addition, the financial responsibility for care services reveals a set of nested interdependencies. Legislatively, the financing of social care services rest squarely with local governments. But, the financing for these services is heavily dependent on a block transfer from the Scottish Government. In recent years, as much as 80% of all public sector spending at the local level was sourced from this central Scottish government grant (Midwinter 2002, p.38). Since Local Authorities are highly dependent on Scottish Government funding, even marginal changes in the level of Scottish Government expenditure could lead to dramatic shifts in the local authority's ability to provide services.

For social care services, this vulnerability is exacerbated by the lack of ring fencing. There is a lack of dedicated funding for particular types of social services or particular groups within the population. As a result, social care services for older people must compete with social care services for other groups such as children and families, while the whole of the social care budget must strive for funding alongside education and housing. While some might suggest that this leads to greater local accountability, care scholars and gerontologists highlight that longstanding ageism within UK government policy has led to a historic under-investment in social care (Townsend 1962; Walker 1982; Senior 1989).

The delivery of care is predominantly the responsibility of the private sector as only 14% of care homes are run by local governments. But the financing of social care and the duty to assess and ensure that care is delivered is, according to legislation, the responsibility of local government. Thus, the social care system is produced day in and day out through their shared efforts. The NCHC document sits at the centre of this relationship, defining the different roles of these organisations and their financial compensation of the efforts which they undertake.

In focusing on the NCHC document, I aim to show how the care home system is organised and the day-to-day work that goes into making and maintaining this system. In order to explore these ‘problematics’, I have organised this thesis as follows.

STRUCTURE OF THE THESIS

In Chapter 2, I give an overview of the care home sector in Scotland, drawing out the policy context and situating the research in this thesis within wider debates about the responsibility for older people’s care. In this chapter, I outline my interest in system-level activity — the policy and planning of care homes services and the organisation of service delivery within the private sector. To understand this systems-level activity, I examined the literature on commissioning and contracting for social care services in the UK. I provide a review of that literature, suggesting that the conceptual frameworks used to understand these processes are limited by their absence of context and practice. I suggest that an embedded, and relational, account of this work is necessary in order to understand ‘how’ these activities actually operate and ‘what’ they mean to the people who they involve.

In Chapter 3, I give an account of my approach to this research, the methods I undertook to generate the research and the conceptual framework I have developed and applied to the empirical material I produced. Traditional studies of policy and politics have a tendency to analyse the production of policy in absence of its implementation (see Meter & Horn 1975; Parsons 1995). There is a long tradition in policy studies which critiques the false divide between policy making and administration/implementation (Lipsky 1980; Sullivan & Skelcher 2002; Stoker 2004; Durose 2011). My research sits within that tradition. Thus, in this thesis, I depict both the national, deliberative creation of policy and the local implementation of this document’s aims and objectives. In extending this analysis to the local level, I investigate the multiple meanings of this national framework agreement within a range of contexts and across the conflicting perspectives of different stakeholders. The voices of the drafters of this text, the implementers of its meaning and the users of this document are each represented here.

Interpretive scholars note the instability of policy meanings — over time and across different actors (Hofmann 1995; Colebatch 2009). As an interpretive case study, I aim to present “not only *what* a policy means, but *how* a policy means” (Yanow 1995, p.111)

which includes the multiple and conflicting meanings that this NCHC document produces. These conflicting meanings do more than provide multiple interpretations — they also have repercussions for the creation and maintenance of the system of care which I study. The people I spoke with in the care home sector talked extensively about the work they do to make sense of the system and to stabilise that meaning in the day-to-day. It is this stabilising work that draws my attention.

I depict stabilisation as a process and show the human labour and technology which go into the production of a stable system of policy meaning and a stable system of care for older people. Since this project traverses the realm of policy creation and policy implementation, it affords me the breadth to examine the meaning of policy across three domains: the design, the practices of implementation and the response from users in the system tasked with taking up and using the NCHC. The translation of meaning from one domain to the next has implications for the system of care. I explore these implications in the final discussion section of this thesis.

In Chapters 4, 5 and 6 I present this empirical material across three fields of action: the creation of policy, the implementation of that policy document in practice, and the response it generates from the intended users. In these three chapters, I show the different stabilisation tactics that go into creating and maintaining this particular set of relationships in the sector.

In Chapter 4, I examine the production of the NCHC text from the vantage point those who were tasked with its creation and some early adopters of this document in the care home sector. I draw attention to the drivers for creating this national framework agreement and the work of framing and assemblage that went into making it a stable tool. This is followed by a close reading of the text itself where I draw out the hierarchies of care that this document inscribes into the organisation and delivery of care services. This is followed by a more nuanced account of the emotional and ethical dimensions of the NCHC's production and the impossible work that contract managers, in particular, felt they faced in their day-to-day work of holding the system together.

In Chapter 5, I look to the implementation of the national framework agreement in practice and the work that contract managers in local authorities do to activate the text and

enrol care homes into its logic. I depict the rational-technical dimensions of this work and the instrumental tools used to ensure care homes meet the information needs of the contract text. I also show the discretion that contract managers use and the emotional labour that is a part of their work, suggesting that they make an effort to support the care home sector in their day-to-day management of the contract.

In Chapter 6, I move on to the use of the NCHC in the practice of running a care home. In this chapter, I depict a set of resistance tactics and show the way that care home managers negotiate the meaning and implementation of the NCHC document. I suggest that they resist through narrative, carving out their own place in the care home sector and pushing back against the ongoing enrolment activities carried out by local authorities. In looking to resistance, I reflect on the dynamics of power in these relationships. This arc of creating, implementing and using/resisting is, on the one hand, a linear, horizontal, narrative of policy implementation over time. It is also, the hierarchical narrative of a policy created nationally, implemented locally and used in a contractually bound third party. This arc of power is explored further in the final discussion section.

In the discussion chapter, I move away from the focus on practice and return to the wider context of care home operations in Scotland. In this chapter, I reflect on the practice of policy making as a whole and the stabilising tactics I think this entails. This thesis could end here, but I think it would then reflect some of the same criticisms I have made of the literature to date — a failure to reflect the context of this work and the unstable terrain it provides. In Chapter 2, I suggest that policy making around care home services for older people, and care homes in particular, is fragmented in its approach — more often reactionary than visionary. I take up this claim and provide a window into the fragmentation in the policy space — showing the work of stabilising in light of the continuing instabilities within the sector, in particular the divergent policy goals of commissioning for older people's services and the ongoing market instabilities which the collapse of Southern Cross PLC reflects.

In the last chapter, I draw out my conclusions about the care home system and the practice of making and re-making that system in the everyday. These are substantive conclusions about the policy implications of designing and implementing policy within a contractual framework as well as theoretical contributions about the way we might think

differently about bureaucratic and market practices as both rational-technical and relational-emotional, in each case underpinned by ethical drivers which reflect the human in policy work.

CONTRIBUTION TO THIS FIELD OF RESEARCH

First, I take a holistic approach to the system of care homes in Scotland in an effort to bridge the practice-based silos I encountered in my research as well as the multiple academic discourses that take up and analyse the delivery and experience of care for older people. Gerontology, sociology, social policy, feminist critiques of care and the welfare state, economists, human rights scholars, students of politics interested in choice and democracy, practitioners providing care — care homes have been studied within each of these domains, but few join up the thinking. In this thesis I take a feminist concept of care — traditionally applied to the study of paid care work — and apply it to policy making. Similarly, I take the area of commissioning and contracting — new terrain in the study of welfare states — and ask questions about ethics and emotions, which are more familiar in the study of human relationships than economics. In this thesis, knit these approaches together to make a more robust framework for understanding the complexity of care homes.

Second, I suggest that the relationship between the public and private sector — the purchaser and the provider of care — is central to the instability in the sector. I look explicitly at the relationships between public sector bureaucrats and private sector providers in order to understand and give a grounded account of the people, practices and relationships that make up the system. There is a fundamental tension between the statutory sector, as a purchaser with a legislative duty of care, and the private sector providers, who deliver the bulk of social care to older people with funding from the public purse. In taking a relational approach to this case, I am able to focus on the tensions and interdependencies between different parts of the system — with a view to finding possible points of intervention.

Third, I focus on practices — on the everyday work of people in the public and private sector — as a way of knowing this system. I suggest that we need to see the system as a whole before we can make decisions about how to change it. I have developed knowledge

of the system from the ground up, based on the work of people who are well placed to make interventions — practitioners and policy makers.

As I have suggested in the opening paragraphs of this chapter, this research is of particular relevance to the on-going debates about the configuration of care home services in modern welfare states. It also speaks to current policy shifts in Scotland, specifically the integration of health and social care systems and the “re-shaping” care agenda in Scotland.

2. CONTEXTUAL REVIEW: CARE HOME SYSTEMS

INTRODUCTION

This research focuses on the production and ongoing stabilisation of a system of care. The failure or inadequacy of the social care system is a long-running theme in policy discussions about older people's relationship to the welfare state. The 'problem' of social care — how to finance it and how to organise it — features in every wave of policy debate about care services for older people, from the reforms of the Poor Laws (1834) to development of the health and social care systems in the 1940s, the community care reforms in 1990s (National Health Service and Community Care Act 1990), and again, now, as Scotland seeks to integrate the health and social care systems (Public Bodies (Joint Working) (Scotland) Act 2014).

The question of who is responsible — individuals through personal insurance, families through kinship support, the state through universal entitlement, or the third and independent sectors through a mixed economy of care — is at the root of these debates. The question of how we age, where we make that transition and who is responsible for managing that process, are each implicated in the way we think about and plan services for older people. These questions frame policy initiatives like personalisation and individualised services (see Social Care (Self-Directed Support) (Scotland) Act 2013) Reshaping Care for Older People (see COSLA et al. 2011), integration and joint commissioning (see Moray Council 2012). As I suggested in the introduction to this thesis, these questions have a long history in the UK. In an effort to understand the organisation of care home services that I depict in this thesis, I have looked to two literatures.

First, I explore the historical context for planning the social care system in the UK. In this section, I draw attention to the tensions that have surrounded the planning and delivery of long-term residential care for older people. This section provides an historical account of health and social care policy for older people. It aims to show the discourses of failure that frame the policy options, and gives a rationale for their implementation. It begins with the historical roots of the current welfare system by reflecting on the construction of care for

older people in the Poor Laws and their amendments (1834 and 1910). Following this, the chapter looks to the ambiguous creation of the National Health Service and the social care system, and the implications this had for the administration of older people's services and spending on their care. Next, it traces the care of older people through the community care reforms of the 1990s and the promotion of local authority responsibility for the planning of care services and the promotion of the commercialised care providers. Finally, it examines the failures of market mechanisms and the promotion of rigorous contracts as a solution to these failures.

At each transition point in this history, the construction of failure in social care prompts a policy solution. This solution is framed by the discourses of failure in which it was initiated. As the trajectory of failure and solution moves through time, we can see that certain dimensions of the problem are never resolved. As these issues have shifted from one field onto another, the 'question' of responsibility obscures the deficiencies of financing and the broader denigration of care and interdependence. This sections draw on Bacchi's (1999) frame analysis and attempts to show the repeated ways in which care for older people is constructed as a failure — a failure of individual planning, a failure of personal independence, a failure to use resources appropriately, a failure to define responsibilities, a failure to give clear information, and so on. These discourses provide a frame which legitimises certain policy solutions and drives the downloading of responsibility from one sector to another.

Second, I examine two of the central mechanisms deployed by local governments in the planning and delivery of social care — commissioning and contracting. This literature on commissioning and contracting in social care is sparse. The majority of empirically-grounded accounts of these practices is based on two large-scale studies on English social care planning led by Personal Social Services Research Unit (PSSRU). As a result, the academic literature has been dominated by one theoretical framework — Le Grande's (1997) typology of 'knights and knaves'. Thus, the prevailing interest has been the 'motivations' of providers and the normative claim that 'sustaining' a provider's professional motivation is at the heart of the commissioning and contracting process.

I give a summary of the main contributions of this literature with a view to demarcating our current thinking about commissioning and contracting. I suggest that the key

contribution of this literature is the articulation that the people and institutions 'matter' to the successful delivery of social care. But, I also argue that there are limits to conceptualising people in terms of their motivations and institutions arrangements in absence of the practices which reproduce them. In keeping with my approach throughout this thesis, my analysis in this literature uses an interpretive lens. To that end, I address the current state of knowledge on these practices in light of what it tells me about the people and processes that underpin the implementation of social care policy in the everyday. I conclude that we continue to know very little about the actual practices of commissioning and contracting, much less the context in which this work is being done.

In the final section of this chapter, I return to the policy debates in social care and give a contemporary account of the tensions that I have explored historically. In this section, I give a brief insight into Southern Cross Plc and its narrative of growth and failure as the largest care home operator in the UK. In this section, I draw out some of the complexities of the social care system and highlight the continuing instability of older people's care. The central aim of these three sections is to outline the context of instability, the role of commissioning and contracting in planning the care home system and the current academic approaches to understanding this field of activity.

CONFLICT AND NEGLECT: CARE HOMES AND SOCIAL CARE POLICY IN THE UK

In this section, I suggest that social care services for older people have gone through three major policy shifts: one in the 1910s during the reform of the Poor Houses, the second in the 1940s when the national health and social care systems were introduced, the third in the 1990s when the community care reforms were enacted. In the history I depict, the planning of residential care reflects a series of marginalising influences within the welfare system. The instability in social care for older people, and care homes in particular, is an important backdrop to the formulation of the NCHC in 2007 as some of the participants I quote in this research draw on the policy shifts discussed here.

First, the organisation, funding and practice of social care tend to come second to the medical model of care provided through the health service (Means & Smith 1998). Within the provision of social care, the needs of older people have historically been neglected (Walker 1982). Residential care suffers from an additional stigma which complicates its

role within social policy (Townsend 1962). As a result, the policy domain of residential care is highly paradoxical as it is both heavily contested yet strangely neglected. Throughout this review, the location of older people's care shifts from one policy domain to another. Responsibility for the direction of policy and the costs of this care become a 'problem' which another policy space is tasked with 'solving'. As a result, policy and practice around older people's care is reactive rather than visionary — there is very little forward planning for older people's care, a trend which is evidenced in the most recent debates and contrasting narratives on 'the demographic time bomb' (Gee & Gutman 2000).

It's worth noting that the history of social care in Scotland in the UK welfare state is usually subsumed within UK accounts of welfare developments. Very little commentary exists which takes an explicitly Scottish focus to the provision of social care, much less with respect to services for older people. As a result, the trends presented below are largely drawn from UK wide policy shifts.

POOR HOUSES AND THE STIGMATISATION OF OLD AGE

Social Policy scholars in the UK often focus on the welfare system that was created in the 1940s during the post-war settlement. There were dramatic changes to the health service and social security system under the National Health Service Act (1946) and the National Assistance Act (1948) that warrant this focus. But, the changes for older people were less dramatic. The mixed market for care in which charities, the state and for-profit companies provide support services to older people with physical and cognitive incapacities was in place before the National Assistance Act 1948 and remains in place today. As such, it seems fruitful to look to the public policy for older people that was in place before the high-profile post-war settlement reforms.

State-funded care for older people was organised through the system of Poor Houses, which was created under the Poor Law Amendment Act (1834). This Poor House system used stigma and marginalisation as tools to promote independence within the populace. Old age and poverty were dual signifiers of dependence. As such, the location of older people's care within the Poor House system was used deliberately to create stigmatisation around old age. This policy was underpinned by the assumption that older people and their families should be responsible for their care: "The 'deterrent discipline' of the

workhouse was felt by many to be necessary even for the aged, partly as an awful warning to the children or other relatives of old people living in the community, but partly as a penalty for what was assumed to have been an improvident or dissolute life” (Townsend 1962, pp.23–4).

The Poor Law’s (1834) provision for older people who had physical and/or cognitive frailties as a result of old age was similar to the accommodation provided to others with low income or resources. Townsend (1962) suggests that the failure to define a firm responsibility for older people’s care meant that those with limited financial or kinship resources were placed in workhouses. According to Townsend’s investigation, older people were framed in terms of the deserving and undeserving poor, usually around notions of good character. Those of “blameless character” might receive support in superior accommodation in a local workhouse or perhaps a Home for the Aged (1962, p.24). This approach to care suggests that one must be ‘deserving’ of support. A life without dependency or addiction or a life spent in consistent employment with strong family relations was likely to afford one a higher quality of care.

Those who were deemed to be of less desirable character might find themselves placed in less desirable sections of the workhouses as a check on the use of public resources: “For old men and women of this kind, the General Mixed Workhouse, with its stigma of pauperism, its dull routine, its exaction of such work as its inmates can perform, and its deterrent regulations, seems a fitting place in which to end a misspent life” (Townsend 1962, p.24). The notion of a ‘misspent life’ reflects that the prejudices around old age have been compounded by the prejudices around poverty. It’s not just the frailty or poverty which lead one to being placed in a workhouse, it’s the decisions of a whole life preceding the moment of frailty. The expectation that an individual should plan for old age continues to inform our approach to care policy (cf The ALLIANCE 2014). Old age is framed, then as now, as a problem which one needs to spend a life preparing to avoid.

The Royal Commission 1905-1909 investigated the state of older people’s care and their relationship to the Poor Houses. This report recommended separate and distinct institutions for the care of older people, which would remove the stigma of being placed in a workhouse alongside the general population and its attendant responsibilities for work, uniform clothing and paucity of accommodation. But, Townsend argues that without clear

guidance on the nature of these institutions or the allocation of responsibility for enacting this change, few changes were made: “It was little use telling [policy makers] that old people should be looked after in different types of institutions if at the same time they were led to believe that there were many exceptions to this rule. They were largely left to their own prejudices about the interpretation of the word ‘deserving’” (Townsend 1962, p.24). In fact, despite the Liberal Welfare reforms of 1906-1914, there was little change to the system of care for older people until the Local Government Act 1929. As Townsend notes: “The needs of the infirm aged and chronic sick in the workhouse were grossly neglected. Far less information on these persons was made available to the public between 1910 and 1946 than was available between 1834 and 1909” (1962, p.27).

The expectation that the responsibility for care lies primarily with the individual and their family was perpetuated through the National Assistance Act 1948. As I show in the next section, the use of means tested entitlements perpetuates the idea the care is a private concern which should be planned for and paid for from personal resources.

Institutionalised forms of care continue to be sources of stigmatisation (Goffman 1968; Milligan 2012). The discursive landscape which informed the Poor Law of 1834 and its review under the Royal Commission 1905-1909 continued to inform the subsequent post-war settlement and the place of older people within the range of entitlements that were created.

AMBIGUOUS RESPONSIBILITIES - A TALE OF TWO SYSTEMS

The welfare reforms of the 1940s created a new universal system of entitlement for the health service and maintained a means-tested system of entitlement for care services. The formation of two separate systems created an intractable set of fault lines in the organisation of services for older people whose needs often cross these two boundaries. The 1946 National Health Service Act envisioned long-term care in terms of clinically defined and medically mediated ‘continuing care’ needs. It was the intention of this act that these needs would be met in institutional ‘nursing homes’. Services would be provided for free through the new NHS. In contrast, the National Assistance Act (1948) stipulated that non-medical care needs such as assistance with activities of daily living (eating, toileting, etc.) would be met through the Local Authority, which now had a duty to provide care and accommodation to those who met the means-tested eligibility criteria. If

we look to the original intentions of the health and social care acts, we can see that each contained policies for long-term care. According to Lewis (2001), it is these overlapping definitions that have led to the confusion of responsibility.

That health and social care systems have overlapping responsibilities for individuals who need prolonged care and support is further complicated by the blurred boundaries between 'medical', 'nursing' and 'care' activities. As older people have tended to be the highest users of continuing care services, the association between continuing care and older people has been fixed in the discursive landscape (Means 2012). This is evidenced by a conflation of certain ideas in the health and social care policy landscape. For example, the discussions about hospital "bed blockers" reflect an assumption that older people's use of NHS services is inappropriate and ineffective (Hanson 2015; Rubin & Davies 1975).

Bed blocking refers to the notion that a person's use of a hospital resources, particularly their placement in a ward bed, can transition from a medical use to a non-medical use as their needs change from acute medical need to care needs (Audit Scotland 2005). The boundary of this transition has been unclear, requiring mediation from social workers and health professionals. For example, in Bevan's vision of the long-term sector, there was a role for hospital-based social workers to facilitate the transition of older people from hospital to community-based supports (Means & Smith 1998).

Some analysts place the failure with central government policies and their "refusal" (Lewis 2001, p.351) to clarify the roles of the NHS and the local authority. The implication of this failure was a gap between policy and practice, through which the services for older people fell unprotected. Although the legislation suggests a dual responsibility for NHS and local governments to meet health needs, there was no clear responsibility for one service or the other to ensure that that these needs were met. As a result, continuing care beds were not protected. As the resource for continuing care beds disappeared, the pressure to meet the 'continuing' needs of older people was placed on community-based services. As this shift resulted from changes in the practice of health administration, rather than an explicit shift in policy the resources for this extension were not made available. The closure of these beds reflects an assumption that the older people's use of these services was illegitimate (Kellett 1993). The problem of bed blocking and the ambiguity of responsibilities for

older people's care prompted a de facto policy of bed reductions and the push to use community based services for older people's continuing care needs.

The administrative troubles that began with legislative boundaries are further exacerbated by the practical organisation of health and social care services. On paper, the health and care systems are distinct entities with different funding structures and different pathways of access. In practice, the first social services departments in the local authority, then called welfare departments, were organised within the purview of the health department (Means & Smith 1998, p.156). Funding may have been allocated separately, but the policy guidance for day-to-day operations and support of older people was driven by the health sector, rather than an independent minister of social services.

This ambiguity continued until the National Health Service Community Care Act (1990). This health services' responsibility was reiterated in the Department of Health's 1989 response to the Griffith's report 1988, which suggested that local authorities should bear primary responsibility for continuing care needs. The English Department of Health's response suggested that the NHS responsibilities for 'continuing care' remained unchanged. In the first forty years of the new welfare system (1948-1993), ambiguities in the administrative boundaries of health and care needs ensured that there was a lack of clear responsibility for whose needs might fall into both categories.

The tensions between the roles and remits of the health and social care systems had particular consequences for older people, whose care needs fall in the gaps of the system. This policy story is riddled with notions of failure — 'bed blockers' represent a failure to use NHS resources appropriately and efficiently, the dominance of the acute-medicine discourse in the NHS is a failure of the NHS' primary care ethic and the administrative ambiguities result in a failure to take adequate responsibility for older people's health and care needs. Ironically, the administrative fault lines between the two systems have more to do with overlapping responsibilities rather than an absence of accountability. And yet, a historical review shows us that these overlaps result in a failure to take appropriate account of the care of older people. The overlaps lead to a rejection of responsibility by the group which had more power and authority. The health service was able to download its responsibilities onto the social services departments in part because they had administrative purview over the activities of the social services departments. Where there

are technical gaps in legislation, solutions to these gaps are filled through the discursive space (Bacchi 1999).

PUBLIC SECTOR FAILURE — PRIVATE SECTOR GROWTH

The chapter moves now onto an account of the failure of the local authority to organise and fund the increased demand for long-term care services, particularly long-term residential care. In this section, I show that the local government administration of the national budget was constructed as a failure, which required the solution of a more efficient market economy. The result is the creation of a commissioning and contract role for local governments and the allocation of a clear line of responsibility for the assessment and organisation of care services for older people.

The Report to Secretary of State for Social Services, 'Community Care: Agenda for Action', authored by Sir Roy Griffiths is, by design, a short overview of the community care policy in the UK. It aims to make recommendations that would "improve the use of funds as a contribution to a more effective community care" (1988, p.iii). The Griffiths report prompted a significant policy shift. First, it recommended that local governments assume primary responsibility for the administration of care services, thus removing the organisational ambiguity around 'continuing care' services. It also recommended a conceptual split between the 'purchaser' of services, i.e. local governments, and the 'provider' of services, i.e. independent, charitable or public sector organisations who compete for contracts with the local authority.

More significantly for the care home sector was the report's recommendations on the 'perverse incentives' within the funding arrangements for care homes. These 'perverse incentives' had been identified in the Audit Commission Report "Making a Reality of Community Care" (1986). The Audit Commission's investigation revealed that a 'loophole' in the guidance on Social Security budget provided a dedicated funding stream to local governments for care home services. The Community Care Act 1990 followed the recommendations of this report by removing the Department of Social Services (DSS) funding stream and clarifying the divisions of responsibility between the health and social care sectors. It also instituted a requirement that local governments develop the independent sector as providers and famously created a purchaser/provider split in local governments to facilitate this directive.

When we look at the rationale for the purchaser/provider split and the development of the community care agenda, it may appear as though this Griffith's report was an important step in the development of non-institutional community-based services. A closer look at the report suggests that the policies and recommendations for 'community care' are more focused on maintaining the existing responsibilities of private sector care homes and shifting the cost of that responsibility on to the local authority. While Griffiths' makes clear recommendations about the necessary reorganisation of finances to support the additional costs of this shift — the crux of the report is not a vision of community and home based supports. At its core interest is the promotion of the care home model over the model of long-stay hospitals — a model that is funded by the local authority, not the UK government.

The Griffiths report informed the 1990 NHS Community Care Act, which clarified this distinction of responsibilities in legislation. It also adopted the recommendations of the Griffiths report in relation to the role of the independent sector. As Griffith's notes "the role of the public sector is essentially to ensure that care is provided. How it is provided is an important, but secondary, consideration and local authorities must show that they are getting and providing real value" (1988, p.vii). The high-profile split of purchaser and provider which was implemented in the 1990 NHS Act was designed to ensure that social service departments sought best value for services, regardless of type of provider. As Griffiths notes, "the onus in all cases should be on the social services authorities to show that the private sector is being fully stimulated and encouraged and that competitive tenders and other means of testing the market are being taken" (Griffiths 1988, p.vii). A close reading of the report shows that the requirement is designed to prevent monopoly provision of social services through the public sector: "It is important that changes in the present systems for using public funds to support community care do not strengthen the potential monopoly power of the public sector" (Griffiths 1988, p.7). Thus, the drive for more community-based services is primarily driven by the expense of the residential care for the social security budget.

Griffith's acknowledges that the 'contribution' of the private sector has mainly taken shape in the provision of residential care (1988, p.7). Although at the time of the report's submission there was some development of domiciliary care, the bulk of formalised social

care was provided in institutional setting. The growth of the independent sector with the changes to social security financing is well documented (Holden 2002). If we view Griffith's recommendations in light of this increase and, importantly, the correlated costs to central government, the recommendations reveal that the driver behind the reforms the proposed inefficiencies of cost: "I have in particular, recommended that a targeted specific grant should be available to social services authorities to enable them to build up services so that people can be discharged from long stay hospitals (1988, p.19).

The policy 'loophole' which allowed for the support and growth of the independent sector was rooted in the organisation of the Social Fund portion of the social security system. This fund allowed for the support of people in residential and nursing care homes with the costs of their care. The Griffith's report adopted the recommendations from the Audit Commission report to redirect the funds allocated through the Social Fund to the local authorities in a dedicated community care budget. In addition, the Griffith's report makes several recommendations that support the promotion and protection of independent sector care homes. Griffith's suggests that there are "dangers in the present system for regulation and inspection of residential and nursing homes which can result in higher standards of provision being required from private (and voluntary) homes" (1988, p.7).

Set in the context of the findings from the Audit Commission, and the perverse incentives for residential care, this requirement offers an implicit criticism of local authority social services departments. The Griffith's report purports on the one hand to specify the responsibilities of the health and social services departments by specifying the unequivocal role and responsibility of the social services department. Griffith's recommendations also come with a suggestion that financing should be reorganised to ensure a targeted budget for the development of community care services. While the responsibilities of this department are promoted on the one hand, Griffiths also argues for a reduction of social service responsibilities through the promotion of private sector providers.

Thus the Griffith's report highlights a series of concerns with local authority management of social services. There are failures in the accounting and management systems. Griffiths recommends that these systems should be updated in order to measure and manage the efficacy of the services which are provided. When framing this need for a revision of data

management systems, Griffith's suggests that "the present lack of refined information systems and management accounting within any of the authorities to whom one might look centrally or locally to be responsible for community care would plunge most organisations in the private sector into a quick and merciful liquidation" (1988, p.viii). The use of the independent sector as a model for efficacy and efficiency is consistent with the logic of the report which seeks to ensure that the clarification of responsibilities for long-term care include an affirmation of the independent sector.

For example, Griffith's argues that the local governments: "social service authority activities tend to be dominated by the direct management of services which take insufficient account of the varying needs of individuals" (1988, p.8). The implicit assumption within this report is that the independent sector will be more able to identify and meet the individual needs of service users. In contrast to Griffith's account of the public sector, he suggests that the 'best examples' of the private sector's provision of care "show how services can respond very flexibly to meet the particular needs of individuals in a way that is acceptable to them and takes full account of their personal circumstances" (Griffiths 1988, p.7). Griffith's view of the problems with social care as it stands at the time of his report are rooted in his sense of system failure: "the system is almost designed to produce patchy performance: good where there happen to be earmarked funds and local goodwill and initiative; poor where, in spite of funds being available, the incentives to plan, prioritise, and organise across the whole field are negligible" (1988, p.9).

The assumptions of the Griffith's report place the model of efficiency in the commercialised provision of care services. As such, its recommendations promote the use of independent sector providers. It further recommends that local governments should promote the market as a solution to the previous inefficiencies. This has implications for both the independent and charitable sector as well as local governments. The loophole in DSS funding had already created a stimulus for the care home market. The purchaser/provider split ensured that the local governments would reduce their own care home services in favour of those that were contracted-out. As the private sector grew, the public sector declined, but the responsibility for local governments to plan and finance the care of older people in their area remained fixed in the National Health Service and Community Care Act (1990). Thus, the interdependence of this relationship between the public and private sector was strengthened.

A FAILURE ON ALL SIDES — LOCAL GOVERNMENTS AND CARE HOMES

The relationship between local governments and private sector care homes is not an easy one. This discomfort, and the instability that it can create, is at the heart of this thesis. In this final section of policy history, I draw on a 2005 market study by the Office of Fair Trading (OFT) which was a response to a ‘super-complaint’ about care homes in the UK (Office of Fair Trading 2004b; Office of Fair Trading 2005). This report identifies a series of failures, both within the business practices of care homes and the local government’s provision of information about the market for care home services. In discussing this report, I show that the creation of a national framework agreement in Scotland (the NCHC) was informed by this report and the failures it identifies. In this way, I establish the NCHC as a ‘solution’ to the failure of regulation and competitive business practices. In this section, I focus on several features of the OFT report (2005). First, its recommendations to local government and care homes and the points it makes about where they had been deficient to date. Second, the OFT focuses on fragility of people entering care homes and emphasises the inequities of power which might lead to the failure of the care home service for the resident.

LOCAL GOVERNMENT FAILURES

The OFT report stipulates that there are “significant gaps” in the information provided to residents about the process of moving into a care home “at almost every stage” of the assessment and placement process (2005, p.3). This includes gaps in the information provided about the range of care homes in the local area and the services they provide, the level of financing available from local governments to cover the costs and any top-up fees (above the local government rate) which care homes might require. It stipulates that care regulators should monitor local governments to ensure this information is provided. Local governments are also charged with failing to provide adequate support to potential care home residents who do not qualify for local authority financial support. The OFT report recommends that Local Authorities ensure that service users are supported through the entire process of a care home placement, regardless of their ability to pay for that service.

The OFT report raises concerns about the information provided to residents about top-up fees. Referencing the English guidance, it states that “individual residents cannot be

required to secure a top-up because of market failures or commissioning inadequacies” (2005, p.6). The report recommends that ‘very clear’ guidance should be given to service users who are eligible for local authority funding so that they are aware there is no need to pay additional fees for their care home placement. The perniciousness of this problem is encapsulated in the OFT report’s statement that “40% of local authorities that we surveyed suspected that more top-ups are being paid in their area than they know about”. This suggests that local authorities are largely aware of this practice, and further suspect that its prevalence is higher than their own records would suggest.

These three points speak to a failure of local governments to regulate the market conditions of care home services. Although they are charged with commissioning services, the failure to prevent top-up payments reveals a lack of regulatory purview of the market operations of the sector. This chimes with the inadequacy of the information provided on care home services. Ensuring service users have full and transparent knowledge of the services provided and the market for those services is essential to ensuring that they make informed choices. Similarly, local authority support is skewed towards government-funded clients. The division of services users into those who can and those who cannot pay for their care reinforces the market logic of the care system. Support is offered on a means-tested basis — those with more resources receive less advice and support and the care they access is treated more as a luxury good.

CARE HOME FAILURES

The 2005 OFT investigation raised serious concerns about the fairness and transparency of care home contracts. The report focuses on several problem areas. First, the majority of care home contracts reviewed (66%) give the provider unfair discretion over the increase of fees. Second, care home residents tended to have no knowledge of a written contract for their care home place. Third, contracts were overly long and complex thereby inhibiting clear communication across parties. Fourth, there is a lack of clarity about whether care home contracts can contain provisions for top-up fees and the extent of those provisions should they be included.

The OFT make two recommendations in response to these findings. First it “urgently” recommends that care home residents are provided with contracts (or statements of terms) for their placement and that the care regulators “ensure that significant

improvements are delivered in the shortest possible time” (2005, p.114). It also recommends that the devolved administrations, make amendments to the appropriate legislation and guidance to clarify local government’s role in contracting.

OLDER PEOPLE AND FRAILITY

The OFT report frames older people who use care home services as frail. In this account, care home services are not an idealised vision of care but a place of last resort. The concerns raised in the opening passage of the OFT report, which I quote at length here to give context to the subsequent discussion, reflect the authors’ impressions of older people as vulnerable and their location with the care sector as potentially disempowered.

Few older people move into a care home because they prefer this to living in their own home. The reality is that the process of moving into a care home is often very distressing for the older person and frequently also for their families. The older person may be coming directly from a hospital stay, as is the case for about half of those moving into a care home and will normally have suffered some kind of loss that necessitates the care home move. The loss could be in physical or mental ability or could be the loss of a partner or relative who may previously have cared for them. Additionally, the move often has to be arranged quickly, with all the stress that time pressure adds, and the older person and their representative may not have much, if any, experience of arranging care. Once settled in a care home, very few older people choose to move to another home (2005, p.2)

The OFT report reinforces this sense of vulnerability in their recommendations around complaints procedures. They cite the concerns which were raised throughout their investigation from charities and other organisations in the field, that “older people and their representatives were often reluctant to complain” (2005, p.11). While their research found that high percentage of older people would recommend their care home (79%), the report nonetheless concludes that they cannot be sure of the “true scale of the problem” (2005, p.11). Older people were thought to have low levels of awareness about complaints procedures, a lack of support for making complaints and fears about negative repercussions should they make a complaint about the service.

The OFT report makes recommendations that older people be provided with adequate information on their right to complain, including the stipulation that an outline of the complaints procedure should be included in the contract document. The OFT also recommends the use of advocacy services to support older people in making complaints

because “older people in care homes are in a vulnerable situation and many will not enjoy the support of friends and relatives” (2005, p.12). The core recommendations regarding transparency and clarification of responsibilities are central to the development of the NCHC which I depict in Chapter 2.

REFLECTIONS

There are several policy stories at play here. First, the needs and rights of older people have tended to be subordinated within a system which is inherently ageist. As a result, policy development in the social services has perpetuated a system of ‘structured dependency’ in which older people are reliant on a marginal level of state subsidy and support (Townsend 1962; Townsend 1981). This is evident in the discussion of poor houses, but it continues in the interactions between health and social care systems today where the bed-blocking older people remain a contentious point of debate.

In light of these stories, some conclusions may be drawn. First, the development of residential care services appears to be largely reactionary. From the reform of the ‘poor houses’ to the management of a new market, Local Authority Social Services Departments have had little opportunity to develop services for their local communities. Furthermore, the development of this system has been structured by the social construction of ageing, gender and family. As a result, the needs of specific users who have been marginalised both within and outwith the social care system appear to have little traction.

This is the terrain in which this research was conducted. Care homes are arguably the most neglected aspect of the social care system, and yet, their location with the welfare system is seemingly under continuous debate. High-profile reports such as the 1988 Griffiths’ Report (Community Care: Agenda for Action), the 1999 Royal Commission on Long-Term Care (With Respect to Old Age: Long-Term Care - Rights and Responsibilities), The 2005 Office of Fair Trading Report on markets for care home services and the 2006 Wanless Review (Securing Good Care for Older People) each grapple with the narrative of failure that underpins social care provision in the UK. Looking to these reports as a whole, we can see that at each developmental stage in this policy story care homes are the least desirable of these services. As a result, they can claim a 200-year history of conflicted responsibility.

In policy, empirical research and the media, the notion of long-term residential care is fraught with terms like ‘abuse’, ‘low-pay’, ‘low-status’ and ‘neglect’ . How can we make sense of these? And where do we turn when we want to invest in making a positive change to this system? These are the questions that prompted this empirical work. In approaching these questions, I first sought to understand the planning of the care homes system. Current planning practices include the work of commissioning and contracting. In the next section, I review the literature on these practices in the field of social care.

LITERATURE REVIEW: COMMISSIONING AND CONTRACTING FOR SOCIAL CARE

Commissioning and contracting are the central processes used in ‘planning’ UK social care – and are reflective of the 1990s marketised policy response. The academic literature on these processes argues that approaches to commissioning and types of contracts have a direct impact on the performance of providers the quality of care delivered. As a result, this literature tends to suggest that commissioning should aim to ‘sustain’ mercantile motivations of social care providers and use low-risk contract types, which favour high levels of provider control. In this section, I explore the significance of commissioning for the planning and delivery of social care services and then examine one of the key conceptual tools used in this literature: motivations. The articulation of motivations is set within the value of commissioner’s work to build a partnership with the care provider. I examine these concepts in terms of the contribution made by the literature and ask what it tells us about the practice of commissioning itself.

The literature spans a twenty-year period from the implementation of the NHS Community Care Act (1990) in 1993 and depicts commissioning as a pivotal process in the making and managing of markets. Without exception, these studies focus on the English context of social care. They are notably dominated by the work of one research unit (PSSRU) which hosts a cluster of researchers interested in commissioning and contracting social care. Most of this research adopts, and extends, Le Grand’s ‘knights and knaves or pawns’ framework. This literature is drawn from the fields of social policy and public administration.

SEARCH STRATEGY

Before addressing my search strategy, I should like to frame this review in terms of three lacuna which I have identified in the literature on social care for older people. First, social care for older people is an under-researched area of inquiry, particularly in relation to other fields of welfare activity such as employment or health care. When compared with the breadth of research on health care and health systems (see Greer 2004a; Greer 2005; Smith & Hellowell 2012; Hellowell 2013), the scope of literature on both the provision of social care, and the systems of organisation which support that care, are still relatively unknown. Second, within the literature on social care for older people, there is a lack of empirical study on the administration of the care system, particularly compared with the examination of the kinds the experience of people accessing or delivering front-line support (Kirk & Glendinning 1998; Wilkinson 2002; Rummery & Glendinning 2000; Keyes et al. 2014). Third, there is particular absence of literature on the Scottish case.

This thesis seeks to fill these gaps by providing an examination of the Scottish case, with a focus on the production of policy at a national level and the implementation of that policy in local governments and care homes. This research also addresses the paucity of research on the administration of care systems and fulfils the need to extend our understanding of care for older people. However, the review itself is limited by the lack of current research on social care in Scotland. I have drawn from a range of English case studies for the empirical evidence in this section, though acknowledge that it is limited in applicability. The Scottish social care system, as I have highlighted in the Introduction, is distinct. Its approach pre-dates Scottish devolution and reflects a long-history of local policy approaches.

In searching for and demarcating the literature on commissioning and contracting, I was struck the differences in scope of these two bodies of scholarship. Commissioning is a relatively new concept and is used predominantly in the UK-policy context to describe the planning of social services. The few scholars who grapple with this concept come from a range of disciplines, such as economics, social policy, public health and health policy. Contracting is a much older and diffuse concept — its meaning is tied to a range of disciplines from law and political theory to social policy and public administration.

In order to define, and limit, the field of inquiry, I focus my review on commissioning and contracting for (a) social care services in (b) the UK. This literature is drawn from the fields of social policy and public administration, and as I have suggested, dominated by the research outputs of one unit: PSSRU. Researchers from PSSRU have worked on a range of projects about commissioning for social care in the 90s and early 2000s, including the Mixed Economy of Care project (conducted with the Nuffield Institute for Health) and the Commissioning and Performance programme. These studies use large-scale surveys and interview data to account of “current practice which reveals a gap between government aspirations and what is happening on the ground (Forder et al. 2002, p.1).

These studies tend to use a mixed-method approach and have an interest in developing typologies as a product of their analysis. The quantitative aspect of this research tends to employ large-scale surveys of local governments and care providers. Qualitative data appears to be used to add nuance to the core quantitative material collected. The primary goal seems to be to map the activities of the sector in a systematic way over time. As a result, there is a robust and iterative development of the theoretical frameworks and an expansion of the original typology (on care homes) to other areas of social care. Early empirical investigations reflect attempts to capture the sweeping shifts in local authority service planning and delivery which came with the ‘purchaser/provider’ split (Kendall 2001). There are also a handful of more recent empirical studies which examine this policy shift over time (Matosevic et al. 2011).

In delineating the relevant literature for this field of inquiry, I have excluded the wider literature on joint commissioning in health and social care (Hudson 2011; Dickinson, Glasby, Nicholds & Sullivan 2013). These integrated models tend to focus on partnership working between the statutory sector (Dickinson, Glasby, Nicholds, Jeffares, et al. 2013). Though some of the theoretical approaches in this work are relevant, the specifics of the partnership that are examined are significantly different from the contractual relationships between a purchaser and a provider which I look at here (Glasby 2012a; cf Hudson 2013). Similarly I also exclude the literature on contracting in other social services, most notably the growing literature on contractual relationships in the health sector (Liebe 2008; Vecchi et al. 2013; Hellowell 2013). During this research, the financial, organisational and legislative realities of local government and their responsibilities for

social care were distinct in Scotland. As result, I have drawn a line round research that focuses exclusively on social care commissioning and contracting in the UK.

COMMISSIONING AND CONTRACTING DEFINED

There are few empirically grounded accounts of social care policy and practice, particularly in relation to care services for older people in Scotland. Some important exceptions include the empirical work include Bell and Bowes (Bowes & Bell 2006; Bowes & Bell 2007) on the SNP's flagship social care policy 'free personal and nursing care' introduced through the Community Care and Health (Scotland) Act 2002 — but even this prominent example of policy change is rarely studied by academics and we continue to have little evidence of it medium-term impact. Other examples of research tend to be located with communities of practitioners (Colston 2013; Gamiz & Tsegai 2014; Caine 2014; Tsegai & Gamiz 2014).

Despite these contributions, there is a dearth of research on social care for older people in Scotland. This trend is visible across the UK. Within this broad research field, empirical accounts of the administration of the social care system are surprisingly absent, especially considering the devolved policy context in the UK. Comparisons between health systems have become more common and add to the substantial field of research on health policy and health systems (Greer 2004a; Greer 2005). In contrast, I came across no peer-reviewed reviewed accounts of commissioning and contracting for older people's services in Scotland.

However, there are some helpful insights into the work of making and managing this system of care within the grey literature. Here are the most notable definitions:

Commissioning includes "all the activities involved in assessing and forecasting needs, agreeing desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place" (SWIA 2009, p.5). SWIA, now known as the Care Inspectorate in Scotland, emphasised that "strategic commissioning is not just about purchasing services from external providers, although this is an important element of the commissioning process" (SWIA 2009, p.5).

Like SWIA, the Scottish Government stresses that commissioning is a broad process within which procurement of independent or third sector services are just one part. Within the Scottish Government’s 2010 Procurement Guidance, commissioning is defined as “the process by which public bodies purchase goods, services and works from third parties. It is not the only method of securing services; other options include the provision of services in-house, shared service arrangements or grant funding” (Scottish Government 2010b, p.5). This process is modelled in the following diagram:

DIAGRAM 1: COMMISSIONING MODEL



Scottish Procurement Guidance (2010b)

If procurement from the private sector is used to commission services, a contract is often a necessary part of that arrangement. The NCHC is defined as a the document that “governs the relationship between local authorities and older people’s care homes across Scotland. The rationale for developing the NCHC was to raise the quality of care provided in care

homes and to standardise the funding of placements local authorities purchase from external service providers for publicly funded clients” (Scottish Government 2010b, p.24).

These definitions from grey literature highlight that commissioning remains a concept most used by practitioners. As there is a dearth of empirically grounded literature on the process of commissioning in social care, particularly in the Scottish context, these definitions from the grey literature are the most useful grounding for the literature to be explored below. As concepts, commissioning and contracting are the terms which are most used by practitioners. As such, any analysis should remain grounded in the meaning they offer to those who use them. These definitions are where I began. When I set out to explore the ‘idea’ of commissioning and contracting within the scholarship on social care, I found no peer-reviewed empirical investigations of these processes in Scotland. What literature does exist is focused on the English case and that is what I examine here.

COMMISSIONING FOR MOTIVATIONS

Commissioning, as defined by current academic research, is the “multidimensional link between purchasers and providers; between planning and activity; between the identification of needs, the deployment of resources and the achievement of outcomes; and between policy and practice” (Knapp et al. 2001, p.294). This echoes the policy-based accounts from SWIA, though the emphasis here is on the ‘multidimensional link’.

Commissioners are the lynchpin between the spheres of strategy and action, and the people who do that work. In this role, they act as translators, working between policy and practice to produce a system of care.

PSSRU’s research on commissioning and contracting for social care began in the 1990s and located within a wider interest in motivations in the field of social policy (Le Grand 2007; cf Taylor-Gooby 2009). In light of the changing policy context (e.g. NHS Health and Community care Act (1990)), researchers sought to find new ways to understand the welfare state and the increasing marketisation and fiscal welfare processes which had become paramount (see Bartlett & Le Grand 1993). As the conceptualisation of the welfare system shifted towards individual rights and personal choice, the focus of research shifted to include an interest in individual motivations (and behaviours). The

programme of research on commissioning at PSSRU is directed by, and drives, this changing view of the welfare state.

But what are motivations? The theorisation of motivations has shifted over the course of PSSRU's research programme. Initial research focused on the expressed motivations of providers (Kendall 2001). Later research expanded this theoretical framework to include the interaction between motivations and the commissioning context (Kendall et al. 2003; Matosevic et al. 2007). More recently, they have focused on local authority perceptions of provider motivations (Matosevic et al. 2008), and changes in provider motivations over time (Matosevic et al. 2011). Through their empirical examination of provider motivations they have extended Le Grande's 'knights' and 'knaves' typology to include a 'merchant' category, which explains a provider desire for a sense of control over their organisational processes and priorities.

Kendall (2001) expands upon Le Grand's (1997) 'knight and knaves' typology by adding a 'merchant' dimension. The motivations of care home providers are categorised into three ideal types: 'empathisers', 'professionals' and 'income prioritisers'. 'Empathisers' have knightly tendencies and prioritise the delivery of quality of care. 'Income prioritisers' have knavish motivations and put profit above other aspects of service delivery. 'Professionals' have merchant sensibilities and prioritise control over their business first and foremost.

The authors suggest that this is not a clear-cut typology, but rather a reflection of the different motivational drivers within the care home sector. Kendall emphasises the potential for overlapping aspects in each of these ideal types: "in essence, these providers are best thought of as combining, with different emphases, knightly, knavish and mercantile motivations (Kendall 2001, p.368). Thus, the 'income prioritiser' type includes the motivation to seek a 'satisfactory' level of income in combination with other motivations such as 'meeting the needs of older people' and 'professional accomplishment' (Kendall 2001, p.368).

In describing commissioning, Matosevic and colleagues suggest that commissioners are tasked with 'stimulating the market' (2008, p.229). On the one hand they must meet the needs of their community and match available resources with the needs presented. On the other hand, they must meet the strategic needs of a market and ensure that the

organisations which operate within their area are appropriately stimulated and nurtured. Likewise, commissioners of care services are responsible for “shaping” the market (Matosevic et al. 2008, p.229) and a well-functioning market is, in turn, thought to be necessary to successful service delivery (Kendall 2001). To successfully shape this market, it is argued that provider motivations need to be “sustained” (Matosevic et al. 2007, p.110) through commissioning arrangements (Kendall 2001; Kendall et al. 2003; Matosevic et al. 2007).

Commissioning that sustains ‘professional’ motivations is thought to maintain quality of care and the stability of the care home system. Commissioners can optimise provider motivations of ‘professionalism’ by ensuring: high levels of information and contact, support for innovation and flexibility, opportunities for provider input into the assessment and care review processes, inclusive partnership working. When these processes are absent, providers are said to underperform (Matosevic et al. 2007).

SUSTAINING PROVIDER MOTIVATIONS

This literature offers commissioners a set of concrete strategies for optimising provider motivations, in particular the ‘merchant’ driver. High levels of information and contact with purchasers (feedback), support for innovation and flexibility (choice) and the opportunity for providers to provide input into the assessment and care review processes (competence) are each thought to ensure that providers’ motivations to maintain control over their business is sustained (Kendall et al. 2003). Matosevic and colleagues found that reliable and comprehensive information sharing encouraged trust with providers (Matosevic et al. 2007, p.118). To which the authors conclude, “national and local authorities need to ensure that their policies and their everyday dealings with care homes sustain and strengthen the existing enthusiasm among care home providers” (Matosevic et al. 2007, p.125).

Partnership working is also thought to produce successful commissioning. Matosevic and colleagues suggest that “if the motivation of providers is to be sustained, they must feel that the local authorities are working with them in partnership (2007, p.110). This conceptualisation of commissioning relationships as partnership is based on the English Department of Health white paper Building Capacity and Partnership in Care which argues that “it is essential” that providers, particularly independent sector providers, are included

in planning, delivery and review of social care services (2001 p.5 in Matosevic et al 2007 p.110). Partnership working is one way of sustaining the 'professional' and 'client-centric' motivations of providers (Matosevic et al. 2007, p.118) and adopting the Department of Health's recommendation of an "inclusive approach" (Matosevic et al. 2007, p.10). The authors suggest that partnership working involves the sharing of comprehensive and reliable information. It can also mean including providers in the care assessment and review process (Matosevic et al. 2008).

The authors make several exhortations to commissioners. For example, they encourage them to leave stereotypes behind and to take provider motivations seriously in the "short term, medium term and long term" (Kendall et al. 2003, p.492). In this literature, provider motivations are thought to be important to quality of care for people who access support. The ways in which "providers are motivated will affect how they engage in such relationships with both purchasers and users, and ultimately therefore have implications for the quality of care delivered" (Kendall et al. 2003, p.492). Kendall and colleagues highlight the potential that commissioning practice will have a negative impact on provider motivations and suggest that local authority approaches to commissioning are leading to an 'underperformance' for providers. The authors go on to suggest that improving the performance of providers should be "a major ongoing policy concern" (Kendall et al. 2003, p.507).

WHAT DOES THIS TELL US ABOUT THE PRACTICE OF COMMISSIONING?

Based on a thorough reading of PSSRU's research publications, I can conclude that, for the authors, commissioning is viewed as a pivotal process for the successful delivery of quality care. PSSRU's researchers suggest that commissioning should facilitate providers to achieve their professional motivations and that this can be achieved if the commissioning process ensures that providers have opportunities to exercise choice and offer input in the commissioning and assessment processes and receive feedback and information (Kendall et al 2003). Inclusive partnership working is thought to facilitate these needs and support a trusting relationship between commissioners and providers. When this process fails, providers underperform.

An understanding of motivations is also thought to be important to creating trusting commissioning relationships. As Kendall and colleagues suggest, "if such trust is to be well

placed, it needs to be grounded in a reasonable understanding of what drives providers, because only then can purchasers be confident that the latter are willing and able to delivery high-quality personal and practical care behind closed doors” (Kendall et al. 2003, p.492). The authors also argue that motivations are important to the function of the social care system as a whole. Half of the sample in the 2003 study “faced either partially or wholly flawed opportunities to express their core motives”; for the authors this is particularly concerning since “those with a responsibility for users’ welfare do not feel able to express their caring aspirations” (Ware et al. 2003, p.507). According to the authors, provider motivations need to be thought of as a policy responsibility for purchasers — both in the short and long-term.

Matosevic and colleagues (2011) suggest that an understanding of provider motivations has become even more important in light of the increasing sophistication of care markets and commissioning processes. Within the ‘unpredictable’ landscape of care for older people which includes shifts in demography, changing patterns of dependency, new dimensions of choice and control as well as the development of more integrated services between health and social care, the authors suggest that knowledge of motivations is important for commissioners to make robust, responsive, decisions.

But, there is very little account of the how this works in practice. How are motivations actually influencing the day-to-day partnership work of commissioning? This literature has been criticised for not focusing on the “exigencies of the system” in which ‘knights and knaves’ work (see (Martin et al. 2004). Care services are distinctly local in nature and they are carried out by particular people in particular settings. Typologies of generic motivations can only tell us so much about the approach an individual commissioner will take to a particular care home. Relationships with providers are seen as a central tenet of successful social care commissioning, but the theoretical framework applied here looks only to individual motivations. Even in the account of partnership working, the purpose of partnerships is to secure appropriate individual motivations from providers. The relational dynamics between commissioners and providers are missing from this conceptualisation.

CONTRACTS AND MOTIVATIONS

The literature on contracting for social care is also dominated by PSSRU researchers and tends to reflect the outputs of some Mixed Economy of Care and Commissioning and Performance programmes. The literature on contracting echoes some of the concerns raised in the studies of commissioning. There are questions about the implications of institutional arrangements on provider behaviour (Forder & Netten 2000; Forder et al. 2004) and partnership working between local authorities and providers (Mackintosh 2000). There are also new areas for exploration, notably with respect to levels of trust (Hardy & Wistow 1998; Powell 1999) and flows of information (Forder 1997)

The salient difference in this literature lies in the focal point of the research. Where the research on commissioning was a study of processes and behaviour, the focus here is on the product — the artefact — of contracting. I argued that very little of the ‘practice’ of commissioning was present in the research outlined above. In this case, there is no particular interest in the processes of contracting. In this literature, the contract is viewed as a tool and the focus is on this tool’s outcomes. There is complete absence of interest in its implementation. In the following sections I summarise this literature’s articulation of the key contract types and their perceived impact on the performance of providers.

CONTRACT TYPES

Within PSSRU’s research, a range of different contract types is examined for the purchase of social care. The most common forms include, grant funding, block contracts, cost and volume contracts, spot contracts, call-off contracts. Each of these contract types have different levels of risk for the purchaser and provider. High risks for providers are flexible contracts which prevent long-term planning on their part. These tend to be low risk for purchasers because they only buy the service they need and are not tied down to a long-term arrangement that they may not need. The degree to which the purchase or provider has control over the service also affects price. Dominant control from either the purchaser or the provider will tend to produce high prices. For example, grant funding to providers gives the provider a high level of discretion over the services and prices tend to be higher in this arrangement. Similarly, spot-contracts tend to give purchasers a high-degree of control (and create high risks for providers), so here too we see prices are higher. PSSRU’s research suggests that different models of contracts appeal to different motivational types. Kendall argues that the providers with a more dominant ‘mercantile’

motivation are drawn to flexible contract arrangements, even though these carry higher levels of risk (Kendall 2001, p.372). I review their account of contract types below.

Grant funding is a block transfer of funds to a provider for the provision of service. They enable a high-degree of provider discretion because the service specification and the number of service users are only loosely determined within the agreement. The arrangements are low-risk and produce high levels of control for providers. These arrangements are also associated with higher prices (Forder et al. 2004, p.216). The authors suggest that higher prices within this group are due to higher levels of control and discretion over the design of services as well as the higher levels of assessment and monitoring which from the purchaser.

Block contracts and cost and volume contracts are the middle of the road in terms of the risk/control, price/nexus. They support long-term planning for providers and low costs for purchasers. These contracts include a formal service specification. The volume of service is determined in advance, which can be useful to providers so that they can plan their capacity and service delivery well in advance. In the case of block contracts, providers are paid regardless of whether the service is used. Similarly, cost and volume contracts include a pre-determined quantity and type of service. There are also provisions within this type of contract for additional service delivery. A pre-determined price for additional services (should they be required) is included in this contract type. Block contracts and cost-and-volume contracts are generally associated with lower prices since these contracts generally allow for a more predictable long-term planning, which ensures prices are more reflective of actual costs of care.

Spot and call-off contracts are the most flexible contract types, but they are also associated with higher prices (not unlike grant funding described above). These contracts have the highest level of risk for providers, because spot contracts are determined for individual service users and agreed at the time of service use. Call-off contracts include a pre-determined price, but the payment and agreement of terms is arranged at the time of service use. Spot contracts, which are particularly common in the care home sector, are typically associated with higher prices because they carry more risk for the provider who can not determine, in advance, whether the service will needed (Forder & Netten 2000, p.654).

SUSTAINING PROVIDER PERFORMANCE

Forder and colleagues argue that “institutional arrangements matter” (Forder et al. 2004, p.207), suggesting that different types of contracts impact on provider performance (e.g. price charged). As noted above, different contract types are associated with different levels of risk, which in turn has implications for price (see Forder et al. 2004, p.212). In their terms, “high levels of contingency” or control in the quantity of service (e.g. block contracts) tend to produce lower prices because the level of service is more predictable. Similarly, high levels control over the kinds of service to be provided (determined by the level of need for the person accessing support) tend to produce high levels of control over the cost of the service. This “cost” control in contracts is generally associated with lower prices because the level of dependency and intensity of service provision are planned in advance which ensures that payment is more closely linked to the service that is needed (Forder et al. 2004, pp.212–213).

Contracts also contain information asymmetries which can create advantages for the purchaser/provider. For example, providers can cream-skim service users with low levels of need (an incentive with high levels of quantity control) or exaggerate levels of need to secure higher-prices (an incentive with high levels of cost control) (Forder et al. 2004, p.213; Forder & Netten 2000, p.647). The type of contract is thought to mitigate some of these asymmetries. In response to these information asymmetries, Hardy and Wistow suggest that local authorities need to cultivate a “mature purchasing framework” which includes long-term relationships, mutual trust, mutual understanding and stability (1998, p.34). These mechanisms, they argue, are a resource that local authorities can use to mitigate the key challenges which had appeared in the early days of the purchaser/provider split. For example, weaknesses in accreditation and review of providers, inflexible contracts, inappropriate types of contract for the service and sector and multiple providers and carers per service user (1998, p.30) are all risks to successful, equitable, contractual relationships.

Hardy and Wistow argue that “both the contracting mechanisms and the approaches adopted by local authority purchasers are compromising the capacity of providers to deliver high-quality care” (1998, p.33). Nevertheless, most social care contracts in

England are spot contracts — highly flexible, but high-cost with poor options for long-term planning and relationship building (Forder & Netten 2000).

Hardy and Wistow's research directs us to the complex relationship between trust and contracting. Hardy and Wistow suggest that "the task for local authority purchasers is to provide sufficient certainty and stability for providers" (1998, p.34). Though it doesn't receive as much attention as their later research, the authors make note of the dissonance between local authority perceptions and the actual motivations of providers: "our research has shown that purchasers were proceeding on the basis of ill-informed stereotypes of provider motivations: 75 percent of those interviewed in our study had a background in the public sector, and their principal motivation was to improve service quality rather than to maximize profits" (1998, pp.29–30).

In their research on contract types, Hardy and Wistow (1998) suggest that stability in the market will be encouraged through the use of block or cost and volume contracts which allow providers to engage in a longer-term relationship with the purchaser. In contrast to their recommendation, the research reveals that spot contracts were commonplace for 79 percent of 55 providers surveyed, a figure which echoes the authors' findings in a national survey in which spot contracts were the only kind of contract used for 65 percent of 225 providers (Wistow et al. 1996). Their recommendation is that a change in contract type would facilitate providers' long-term business planning and create more equitable division of risk across the purchaser and the provider.

WHAT DOES THIS TELL US ABOUT THE PRACTICE OF CONTRACTING?

This research focuses on the artefact of contracting — the contract document and its role in the performance of providers. The typology of contract types tells us little about the practice of contracting, but it does obliquely reveal some insights into the researchers view of local authorities and their role in the market. In this research, local authorities are thought to be responsible for managing the market: "the position of local authorities as a major purchaser and sponsor for clients in the independent residential care market, which was entrenched by the 1990 National Health Service (NHS) and Community Care Act, gives them both the scope and obligation to manage and share these social care markets" (Forder & Netten 2000, p.644).

The adoption of an 'enabling' role for the state is one of the central tenets of new public management (Forder et al. 2004, p.208). Local authorities are thought to be enablers because of their purchasing power: "local authorities are powerful purchasers in the domiciliary care market". They have the power to affect both the level and the flexibility of pricing" (Forder et al. 2004, p.218). This is echoed by Forder and Netten who suggest that "local authority social services department are the dominant purchaser of residential care" (2000, p.646).

There are certain assumptions built into this analysis — particularly around a provider tendency to game the system. Information asymmetries are thought to lead to providers exaggerating the needs of service users to gain higher prices or cream-skimming low-dependency service users because they are low-cost (see Forder & Netten 2000, p.647; Forder et al. 2004, p.213). Contracts, in their view, have an important role to play in the governance of the sector — they can limit the adverse tendencies of providers to game the system — they can also limit prices, which in turn can impact quality of care (Forder et al. 2004, p.218). As Forder et al suggest, "contract choices do have a significant and substantial effect on market prices" (Forder et al. 2004, p.218).

Since the 'practice' of contracting is absent, there is a gap between the asserted importance of the local authority's role in 'managing the market' and the actual activities which produce that stabilised system. Similarly, this focus on 'gaming' is a dominant analysis in public policy, which tends to over-emphasise these processes to the exclusion of research and analysis on other aspects of the market and market relationships (Bennett 2013). Like the review of commissioning detailed above, I suggest that social care is a local activity with local service providers and localised care needs. The context and the practices of contracting are strangely absent from these accounts. In the empirical chapters below, I seek to include those dimensions and expand the current conceptualisation of contracting to reflect the activities of people doing this work in the relationships and contexts which are central to their practice.

To drive home this point, I present a short set of observations about the care home system. In the following, final section, I provide an insight into the operational organisation of one care home organisation: Southern Cross. This organisation went into receivership during this PhD project and was often referenced by the participants in this research. In

presenting this account, I take up my claim that the context of care home and local authority practice is missing from the literature. This account also provides a current example of the market for care homes discussed in the policy review above.

INSIGHT INTO A CARE HOME ORGANISATION: SOUTHERN CROSS PLC

I have suggested that the intricacies of the care home system are often missing from accounts of policy making and planning. To give credence to that argument, I return to the context of care home provision in the UK and focus on the narrative of expansion and eventual collapse of one care home company. This example illustrates the complexity of the care homes system, which I find to be absent in the accounts of the system and the people who work within it as outlined above. It also serves to highlight several of the key themes of this thesis and provides a salient example of the different methodological and theoretical approaches which are required to understand the provision of care to older people.

This account of Southern Cross reveals several dynamics in the social care system which I build upon in Chapters 4-7. First, this system is highly complex — even one provider can encompass multiple subsidiary organisations, separate ownership and management arrangements as well as a highly individual history of growth and collapse. Second, I suggest that the Southern Cross failure revealed the interdependence of the state and private sector providers of social care — neither can provide care to older people without the other and each is a necessary part of the current configuration of social care in Scotland.

Southern Cross PLC was the largest care home organisation in the UK when it went into receivership in 2011. At that time, it operated 735 care homes and 37,425 beds (Southern Cross Healthcare 2008). Southern Cross had many incarnations. Originally called 'Southern Cross Healthcare Limited', it was founded on December 7, 1995, but was shortly repurposed as Southern Cross Healthcare Services Limited was created on July 2, 1996 (Companies House 2009b; Companies House 2009c). In 1997, Southern Cross was incorporated under the name 'Southern Cross Healthcare Group' (Datamonitor 2009). At that time, it operated 801 beds in 17 homes in the UK (Anon 1997).

By the time of its failure, Southern Cross was subdivided into several different brands, for example: Southern Cross, Ashbourne Senior Living and Active Care Partnerships. It also had over 80 subsidiary companies: Southern Cross Alexandra Propco Ltd, BC Opco Ltd, Belhaven Propco Ltd, Belmont Propco Ltd (Companies House 2009a). These companies serve to reduce risk to the parent company, Southern Cross Healthcare Group Plc, and its shareholders.

Originally a privately owned company, Southern Cross was bought by venture capitalist, West Private Equity, in a management-led buy-out for £80 million (Chinwala 2002). At the time, Southern Cross was the third largest care home operator with 139 homes and 7,600 beds (Chinwala 2002). This trend of equity-ownership continued and in September 2004, a private equity firm The Blackstone Group initiated a second management-led buyout of Southern Cross for £175m (Anon 2004). At the time, Southern Cross was made up of 150 homes with 8,000 beds (Anon 2004). This buyout represented US-based Blackstone's first foray into the UK market. Blackstone floated Southern Cross on the stock exchange at the share price of 225p in July 2006 (Urry 2008). At that time, Southern Cross was one of only two care home operators to be traded on the London stock exchange (the other was Caretech) (Forston 2006).

Southern Cross has operated an aggressive growth through acquisition business model. It sought the acquisition of smaller care home operators such as Ultima (26 homes), which it bought in 2001 and Trinity (26 homes) which it bought in 2002. Southern Cross bought Eastwood (9 homes) in 2003 and then Intercare (5 homes) in 2004. At this time, the group began to engage in larger acquisitions such as the purchase of Highfield (186 homes). Other acquisitions include Crown Health Care Group (5 homes) and Rozelle care homes (5 homes), which were acquired in 2005 (Datamonitor 2009). Aggressive acquisitions continued after Southern Cross entered the stock market. These include the purchase of Life Style Care (23 homes), Focus Healthcare (29 homes) and Avery Healthcare Limited (15 homes) in 2007. Bondcare Group (39 homes), Portland Group (7 homes) were bought in 2008 (Southern Cross Healthcare 2008; Datamonitor 2009). These acquisitions fit with Southern Cross' aim to increase their bed numbers by 2000 each year (Douglas 2008b).

This model of aggressive acquisitions and growth was facilitated by a 'sale and leaseback model' which allowed Southern Cross to sell newly acquired care homes to real estate investors and then lease them back. Also known as an Opco/Propco model (operating company/property company), this business design is a cheap way to buy into the £12 billion per year elder care sector; it allows the operating company to acquire the business without the burden of carrying new equity (Urry 2008). Southern Cross' growth has increased its competitive advantage which in turn influences its ability to negotiate lucrative fee agreements from local authorities (Williams 2008). Since local authorities account for 70% of Southern Cross' revenue (Anon 2008), even very slight fee increases can cause a significant rise in revenue.

In the face of the economic downturn in 2008, then CEO Bill Colvin said that Southern Cross would be largely unaffected given the steady demand for its services: "Demand for our services is inelastic so we can look forward with confidence regardless of the economic conditions. People still get old whether there are good economic conditions or not" (Douglas 2008a). Southern Cross also welcomed the prospect of rising levels of unemployment because it would keep wages affordable (Douglas 2008a).

Two years after these 'promising' reports were made to shareholders, Southern Cross was in the financial papers as its Opco/Propco model faltered. This model relied upon secure and steady care payments from local authority and similarly predictable rental payments to the owners of the land/building where Southern Cross operated its care home. After the financial collapse in 2008, the reliability of their leases came into question as investors grew risk adverse and local authorities started to cut back on care budgets, which meant a 0% increase in care home fees. Southern Cross was overextended and began to try and sell care homes to increase their liquidity. This was a national news story for weeks in the lead up to the company's inevitable collapse with calls that Southern Cross was too big to fail (Anon 2011b). The interdependence between local governments and independent care home providers rings out in this narrative. There was no capacity with the NHS or local government-run care homes to take on 40,000 new residents — a practice reality which I learned during my fieldwork and which I explore in the subsequent chapters.

DISCUSSION

In this contextual review, I have provided the historical context to the delivery of care for older people in institutional settings. This model of care has a long history — one that pre-dates our conception of the modern welfare state. I stress this point because care homes for older people are too often elided into the policy narratives around domiciliary care, or indeed, the NHS. In fact, these homes have a long history within the voluntary (particularly religious) sector, for-profit sector and public sector. This is not an idealised history — many within social policy have criticised these origins, notably Townsend (1962) and Walker (1982).

I emphasise the point here to make clear that the ‘market’ for care homes was not created with the Community Care Act 1990. In fact, I have suggested that the market for care homes was considered to be ‘out of control’. One of the functions of the Community Care Act 1990 was to close the funding loophole in the social security funding which allowed an unlimited amount of money to flow from the Social Security Budget into the private sector care homes supporting older people.

This policy response is just one of the many instances in which care homes policy, and policy for older people’s care more generally, has been reactive rather than visionary. Care homes have been a policy ‘problem’ since the Royal Commission’s reviews in 1905. The issue of responsibility — the family or the state — was raised then and continues to rear its head now. The issue of bed blocking — of tying up valuable NHS resources, which prompted the reduction of continuing care beds and the subtle downloading of care onto the local governments, is still an issue today as the integration of health and social care in Scotland is implemented (Public Bodies (Joint Working) (Scotland) Act 2014).

That we have not ‘solved’ these policy issues is one of the driving forces for this research. I approach my analysis of the system for care homes with the view that we badly need to understand the mechanisms of planning this care across multiple sectors in order to find possibilities to intervene and transform it. I suggest that an embedded (Granovetter & Swedberg 2001) and situated (Haraway 1988) account of that system is necessary to an understanding of the ‘work’ of making and re-making the system. I also suggested that points of intervention and transformation are only possible when the ‘particularities’ of the context and the people within it are examined. To that end, I have provided a brief

insight into the complexity of care home operations in the sector with my analysis of Southern Cross PLC.

In light of this context, I have asked specific questions of the literature on the planning of social care in the UK. My account of the literature on commissioning and contracting suggests that this literature fails to account of the context I have carefully described in this chapter, much less the realities of practice, local government politics, markets and population needs. In particular, I have highlighted that the current conceptualisation of contracts focuses on the artefact alone — with no space for the process of ‘contracting’ which inevitably surrounds the production and implementation of the document. I have also suggested that the literature on commissioning focuses on relationships without giving a robust account of those relationships and the ways they play out on the ground, in the realities of markets and bureaucracies. I conclude that the literature’s theoretical approach is limited and use those limitations as starting points for my own research in this thesis.

In addition, I emphasise that the analysis of ‘motivations’, which is central to the research produced by PSSRU, applies a normative framework in which commissioners and contracts ‘should’ support and ‘sustain’ the professional motivations of providers. Contract types should be chosen which are low risk and promote stability. Likewise, approaches (as vague as those may be in this account) should focus on enabling professional behaviour from providers. This position denies the duty of care which local governments are tasked with under the National Assistance Act 1948 and assumes that commissioners lack any motivations of their own — to promote the wellbeing of the people in their local community for example.

This literature identifies the issue of trust as a central feature, perhaps even need, of the system. This observation chimes with my own findings, discussed later in chapter 8. As suggested above, concepts like trust and partnership are relational ideas and they warrant a relational analysis. Furthermore, the complexity of care home organisations that I have illustrated with the Southern Cross example is far more complex than the typologies of contract types or provider motivations allows. How can we understand something like the opco/propco model of ownership in which care homes buy and sell back the property

within these static models? They provide a valuable set of concepts, but these ideas need to be tested in the complexity of practice.

Finally, as I have suggested, the National Care Homes Contract is a framework agreement which binds each of the 32 local authorities and the hundreds of care homes across those jurisdictions into one contractual agreement. There is no competition for price. There is no need to commission care home services. This is an unusual way of organising care home services and aligns, as I will show, much more closely with policy making. In light of the breadth and strength of this contract, the existing literature can only offer modest insight. As research on social care, and older people's care, is still surprisingly sparse — this is less a criticism of the contributions of PSSRU and more a comment on the lack of diversity of perspectives on the complex field of activity.

3. THEORY AND METHOD

INTRODUCTION: DEVELOPING AN EVERYDAY PROBLEMATIC

In the prologue to this thesis, I described some of my own experiences with the care system and the ways these have driven my approach to this research. Institutional Ethnographers suggest that “all knowing is grounded in somewhere” (Campbell & Gregor 2002, p.13). In the prologue, I took you to Canada, where I’m from, and showed you a small piece of my care work there. Now, I bring us to Scotland, where this study is set, and begin again with the ‘problematic’ of this research. Studying the Scottish care system allows me to look at something familiar in an unfamiliar setting. There is a system of technical-bureaucratic work happening in Canada behind the front line service delivery, but it is organised and talked about differently. As I got to know the Scottish care system through my fieldwork, I developed a more refined problematic with which to approach and make sense of my fieldwork. The interest in invisible work is the same, but now the problematic is based on the conversations and observation I did, my understanding of the UK policy context, and the academic literature on commissioning and contracting for care (as presented in Chapter 2).

For this research, I spoke to people who work in local government as heads of service, social workers, commissioners, contract managers and resource workers. I spoke to people who work for the Care Inspectorate as inspectors and regional managers. I spoke to people who own and manager care homes. I spoke to policy officers and lobbyists from COSLA and Scottish Care, the national representative bodies for local government and private sector care providers. The stories they told me gave me a sense of people whose work is geared towards holding things together in a complex system. Following on from this, I began to explore, and explain how the care home system is organised. I describe this work in detail from a variety of perspectives in an effort to show the subtlety of the negotiation that builds and maintains the current system of care homes in Scotland. I have come to think of this work of ‘holding things together’ — as a kind of stabilisation work and the people who I spoke to as stabilisers of a complex system of care which crosses the

boundaries of the public and private sector as well as the public and private spaces of our society.

In order to detail 'how' I came to these theoretical, and substantive claims about the care home sector in Scotland, I have organised this Theory and Method chapter into three sections. First, I outline my approach to researching policy and the emergent research design I applied to the field. Second, I describe the theoretical framework that I have developed through the iterative tracking back and forth between the empirical findings and conceptual tools. Third, I describe the methods that I used to generate the empirical evidence that is presented in this thesis, paying attention to the stories that emerged from the interview data that was generated.

Throughout this chapter, I focus on the iteration between theory building and the generation of empirical findings. This is an emergent study. As such, key points of discovery in the field prompted me to develop, and adapt, my theoretical approach. Most significantly, conflict in the field directed me towards new theoretical terrain. The iterative tracking back and forth between theory-building and data generation has been creative and productive. It afforded me discoveries in the field which contribute to substantive findings about the social care system in Scotland and instigated the development of a new theoretical model for translation

In an effort to provide a reflective account of that iteration, this chapter includes sections on research design, the theoretical framework and methods for data generation. It is typical in most social science PhDs to separate these sections, providing two shorter chapters on each. I have opted to combine them here to stress the generative nature of this work and the contribution to both theory and new empirical findings I have made. In this research, research design, theory-building and data generation had to be responsive to each other. The final product of this thesis is more robust as result of this responsiveness. I have deliberately organised this chapter to reflect the overlapping nature of these three phases (design, theory and method).

This chapter is divided into three sections: research design, theoretical framework and methods. In the first section, I outline my approach to researching policy and the use of an interpretive lens to understand the everyday practices that people carry out and the

meaning they bring to them. In the second section, I depict the theoretical framework that I developed for this analysis, giving an overview of ANT and IE and the need to make conceptual space for power and emotions in the depiction of translation. Third, I describe the methods that I used to generate the evidence presented in this thesis, paying attention to discovery and conflict in the field and that ways that has shaped my theoretical approach.

RESEARCH DESIGN

In this section I outline the interpretive approach in this research, noting my interest in multiple perspectives and the “communities of meaning” that support their development (Yanow 2003). Interpretive approaches lend themselves to an emergent, and interdisciplinary, methodology — one which is responsive to the research context and the learning which occurs in the field (Schwartz-Shea & Yanow 2006).

AN INTERPRETIVE APPROACH

This thesis examines three phases of policy: creation, implementation and use. In the following section, I unpick my understanding of policy and policy-making, I focus first on the interpretive approach I adopt, and then I outline my operationalisation of this approach in terms of the methods I used. I think of interpretive approaches as a “broad church” (Stewart 2012, p.50), including scholars who identify themselves explicitly as ‘interpretive’ and link themselves to scholarly debates about positivism and post-positivism, and those local government scholars interested in the mostly hidden activities of local policy making and service delivery. I draw on this approach to justify my exploration of people and their local contexts as a way to understand policy.

Interpretive policy analysis (IPA) focuses on meaning making in local contexts by the people directly engaged with the development, translation, use and impact of a policy. It is primarily interested in ‘what’ a policy means as well as ‘how’ it means (Yanow 2000, p.8). In other words, interpretive approaches focus on both the ‘context-specific’ meanings of a policy and the processes through which those meanings have come about. IPA assumes that policy is ‘action-oriented’ and ‘interventionist’ in nature and seeks to uncover the ‘normative’ and ‘interactive’ dimensions of its production (Wagenaar 2011, p.127).

Interpretive approaches are often set against positivist policy analysis which is critiqued for its reduction of complex, multiple, meanings into a singular universal empirical 'fact'. A positivist approach is, as Yanow suggests, driven by the "assumption that policy words can have univocal, unambiguous meaning that can and should be channelled to and directly perceived by implementers and policy-relevant publics" (Yanow 2000, p.6). It is suggested that this kind of analysis suits the needs of policy makers who want to know 'what works'. The interventionist nature of policy making seems, to some, to demand a set of rational solutions based on robustly acquired scientific data which is value-free and objective.

Interpretive approaches resist this kind of rational instrumental approach and the assumptions within it. Instead, they tend to rely on a very basic tenet: "as living requires sensemaking, and sensemaking entails interpretation, so too does policy analysis" (Yanow 2000, p.5). In doing this sensemaking, scholars who adopt an interpretive approach to policy place a high value on three attributes in their research: the local particularities of context, the practices which make up people's doings, and meaning in context and practice as well as the interaction between these dimensions (artefacts, people and meaning). Recent investigations of policy-making as a practice pick up on some of the differences an interpretive approach to policymaking offers. Freeman, Griggs and Boaz (2011) suggest that our current thinking about policy tends to frame it as an "abstraction" viewed primarily as a model or set of instruments (p128). In this way, we understand policy in terms of Kingdon's (1995) template for policy change or Sabatier's advocacy coalitions (1991) — rather than the messy, everyday work that it often entails. By viewing it in these terms, we try and fit the mess into the model — rather than looking straight to the sensemaking work that people already apply to their activities. Similarly, we might think of the artefacts of policy as a set of tools which can be compared in terms of the ends they seek, rather than the way they are adapted or resisted. As rational tools, we might assume that these artefacts are transferred from national to local settings without revision or interpretation. From this vantage point, policy is fixed — and the gaps between policy and practice are a failure to be remedied rather than a resistance to be understood.

In contrast, there is a strong focus on plurality of experience in interpretive approaches — usually explored through multiple meanings and local knowledges. To get at these realities of the policy process and its impacts, interpretive scholars suggest that we should

look to the “very mundane, yet expert, understanding of and practical reasoning about local conditions derived from lived experience” (Yanow 2004, p.12). This local knowing is at the heart of the ‘interpretive turn’ in the social sciences, which Yanow suggests is the “turn from trying to explain social phenomena by weaving them into grand textures of cause and effect to trying to explain them by placing them in local frames of awareness” (Geertz 1983, p.6 Yanow 2004, p.12). To get at this multiplicity of meaning, Yanow (1993) explores the implicit understandings of local policy actors and sets this against the explicit meaning as encapsulated in the text of a policy document. In this way, she draws attention to the divergent meanings which can occur between the people who draw up legislation and those who use that policy such as “agency staff, clients and other policy stakeholders” (Yanow 1993, p.42). This ‘use’ of policy is most often explored through the practices of people in their local contexts as they go about working with (and around) policy to deliver services or access support. Likewise, Wagenaar offers an alternative to behavioural modes of understanding work which focus on the ways people fit with institutional rules and norms, suggesting that “actors who are engaged in a particular activity produce the proper activity through their emerging understanding of what is right or fitting in that particular situation” (2004, p.644). Thus, he suggests that it is people working together — their actions and interactions within the local context — which developed shared meaning and knowledge of what to do, how to do it and whether it is ‘right’.

OPERATIONALISING AN INTERPRETIVE APPROACH

I take several points of inspiration from IPA’s approach to policy analysis. The emphasis on people and the particularities of their experience and context are central to this kind of research. Interpretive approaches are said to “focus on the meanings that shape actions and institutions and the ways in which they do so” (Bevir & Rhodes 2002, p.131). Interpretive scholars tend to assume multiple meanings and place a high value on exploring those meanings in local contexts with people who make, use and are impacted by policy. I adopt that stance in my approach to policy making, policy implementation and policy use in this thesis. In particular, I take up the focus on ‘interactions’ which have been so fruitful to Wagenaar, Forester and Yanow, looking first to the interactions within ‘communities of meaning’ (Yanow 2003) as well as across those domains.

By focusing on the translation of policy across three domains, I differ in approach from some of the dominant trends in interpretive approaches — as well as similar approaches

in local government studies — which tend to look solely at one level of policy making (e.g. local administration in the case of Wagenaar (2004) and national government in the case of (Bevir & Rhodes 2003) Though unintentional, the deep analysis of particular domains of policy practice that are so common in an interpretive approach serves to reinforce the divisions which scholars have sought to unsettle — namely the divide between national policy communities which design policy and local communities which implement and use those frameworks in their everyday activities. To address this gap, I explicitly direct this research at three levels of policy making: national, local government and service delivery within the private (independent and third) sector. In focusing on these three levels, I maintain IPA's contention that policy-making is best understood through doings and complex contexts of everyday people — rather than through a top-down model to which people's practices are ascribed.

In looking to these practices, I unsettle the divide between the political work of creating policy and the administrative work of implementing policy. Local government scholars, beginning most famously with Lipsky (1980), have argued for the value of a bottom-up analysis of policy-making. Scholars within this tradition suggest that “policy can effectively be ‘made’ as it is being implemented” (Durose 2011, p.13). For example, Maynard-Moody and Musheno (2000; 2003) suggest that the people who do the administrative work of the state are, in fact, creatively enacting policy. Like Lipsky, they take us beyond “legislatures or top-floor suites of high-ranking administrators” to the “crowded offices and daily encounters of street-level workers” (Lipsky 1980, pxiii in Maynard-Moody & Musheno 2000, pp.340–1), arguing that since “they deliver the services, they actualize policy” (Maynard-Moody & Musheno 2000, pp.341–2). I take up this focus on the local practices of policy making, as they are enacted by practitioners in local government and managers delivering services, and use it to complement and extend the more familiar approach to national policy creation.

DESIGN

I have used an emergent research design common to interpretive methodologies (Prior 2003; Charmaz 2008; Hesse-Biber & Leavy 2008). The emergent nature of my approach became significant as I encountered unexpected dimensions of the care home system in my fieldwork. I began with an interest in the organisation of the care homes system and sought to find the locations of that organisation, the people who do that work and the

documents or tools they use to carry it out. As described in chapter two, the academic literature on planning in the care home systems is limited, especially for the Scottish case. What literature does exist focuses on commissioning as the central locus of that work with the contract as a tool to facilitate it. As I soon discovered, the care homes system in Scotland is organised differently. In place of the use of commissioning, the Scottish care home system is primarily structured through the National Care Homes Contract. Thus it is this document and the practices which enable it which became the focus of this research.

My original research design included a plan to focus on commissioning at the strategic level (e.g. between care homes and local governments) as well as the micro-commissioning practices which occur between the person accessing support and the care manager (usually a social worker) when the services are being planned. When I began to interview commissioners in Scottish local authorities, I was told that they 'don't commission care home services' and 'that's all done within the NCHC'. As a result of these conversations, I realised my original design would not be appropriate. Other kinds of care services, such as domiciliary care or residential care for children and young people, may be organised through commissioning in Scotland, but that care home services for older people are distinctly different. Accommodating this discovery in the field opened this research up to new terrain — the NCHC document — an unexpectedly powerful framework agreement which organises care home services across all 32 local authorities. I adapted my research design in response to this discovery.

Originally, I had set out to conduct a multiple case study using ethnographic methods including observation of day-to-day work practices in three local governments in Scotland. However, the system was much more opaque and difficult to access (as I go on to describe later in this chapter). As a result, my neat plans for a multiple case study analysis (Stake 2006) became a thorough mapping exercise of the difference facets of the sector, revealing to me just how little we know about this work of planning, organising and delivering care services. The necessity of this mapping exercise cannot be underestimated. There are no evidenced-based accounts of the organisation of the social care system in Scotland. Some knowledge can be drawn from the grey literature (as I show in Chapter 2), but this tells us little about how this work is done or who bears responsibility for it. The discovery that a national framework agreement, the National Care Homes Contract, is at the heart of this

organisation is a result of the scoping work I undertook to understand the system from a variety of perspectives.

With each new interview, I sought to map the relationships between different parts of the system. This mapping included interviews with a range of stakeholders who work within the planning and delivery of care home services. In total, I conducted 31 interviews (some of which were joint interviews) with 38 people involved in the practical design, implementation and delivery of care home services for older people. I interviewed heads of service, operational leads for older people, commissioners, contract managers, quality assurance officers and social workers (totalling 18 interviews with 23 people). I also interviewed three people from the Care Inspectorate and individuals from Scottish Care, COSLA and Scotland Excel. In addition, I interviewed nine people who manage care homes in Scotland (a full list of interviewees is listed in Appendix 1).

The focus of this research is organisation of the care home system in Scotland. In discovering that a contract document is the primary organising device, I set out to understand that document and its translation from creation, to implementation, to use. In focusing on the processes of translation and the stabilising work that the document, and its creators/users seek to achieve, I have narrowed my focus from a description of the system as a whole to an analysis of how that system is produced and re-produced in everyday practice. In focusing on production and re-production, I have confined my analysis to those participants who actively created, implement, and use the document. There is risk in taking this approach. I have focused on an in-depth account of the narratives of thirteen interviewees in three parts of the system over a broad account of the experiences of 31 participants in seven different parts of the system (policy, commissioning, contracting, quality assurance, care home management, social work and inspection). While an overview of those seven areas of work would be a worthwhile PhD, it would not be a PhD about the practices of translation. A robust account of translation, as I go onto to show in my theoretical framework below, requires an attention to implicit, taken for granted processes. In focusing on thirteen interviewees and the work they do, I seek to make the everyday, technical, relational and emotional work of translation visible with this thesis. This is the primary aim of the thesis. Where relevant, I have drawn more widely from the interview data (notably in the discussion of commissioning in Chapter 7).

In order to understand the NCHC document itself, I also carried out an interpretive analysis of the 2009 contract — paying attention to the content, themes, format, style, and meaning. Analysis of the document itself forms the basis for understanding how it has been used and some of the conflict that it creates. The technical, bureaucratic, work I depict in this thesis is grounded by this document analysis — which both describes and explains fundamental assumptions which are embedded in the text. Further details on the process of analysis are described in detail in the methods section below.

In this thesis, then, I focus on 13 interviews, paying attention to the thick detail (Geertz 2001) and stories (Forester 1993) I heard. The anonymised names, organisations, and simplified professional roles of these 13 individuals are listed in the table below. A copy of the informed consent, research information sheet and University of Edinburgh ethics self-audit tool are also included in Appendices 2, 3 and 4. I also focus on the document itself, and the structuring devices that are embedded in its text.

TABLE 1: LIST OF INTERVIEWEES

	NAME	ROLE	ORGANISATION
1	Harry	Policy Analyst	Scotland Excel
2	Mark	Head of Community Care and Housing	Local Authority E
3	Alexander	Policy Analyst	Scottish Care
4	Carl	Commissioner	Local Authority F
5	Steven	Contract Manager	Local Authority A
6	Sarah	Contract Manager	Local Authority B
7	Penny	Contract Manager	Local Authority C
8	Michael	Contract Manager	Local Authority D
9	David	Care Home Manager	Oakleaf Care Home
10	Tom	Care Home Manager	Beech Care Home
11	Stanley	Care Home Manager	Stillwater Care
12	Joe	Care Home Manager	Shady Pines Care Home
13	Martha	Care Home Manager	Cairngorms Care Home

I have suggested that the aim of this work is to understand the organisation of the care home system. Some of that organisation falls, undoubtedly, to the people to provide the emotional and physical care that is meant to be the *raison d’être* of the care home sector. Given my interest in the strategic planning and operations of this system, I did not interview people involved in the interpersonal, front-line, delivery of care services to older people (though some care home managers did describe their involvement in that work). While this frontline work continue to be under-researched, there is some knowledge of the

practices of care for older people and the possibilities and constraints it offers to people accessing support (Diamond 1992; Armstrong et al. 2009; Daly et al. 2011; Milligan 2012; Gubrium 1975). In contrast, there is no academic literature on the National Care Homes Contract or the practices of contracting. Likewise, there is no academic literature on commissioning for care in Scotland. The sparse literature that does exist on this process of planning is mostly focused on the English context — though even there scholars acknowledge the dearth of research, particularly with regard to social care (Hudson 2013; cf Glasby 2012b).

My research questions reflect my concern to explore this gap:

1. How is the care home system organised in Scotland?
2. What kinds of work does this organisation require?

In the following sections, I go on to detail the iterative approach I took to theory building and data generation (Charmaz 2006). First, I outline the theoretical perspective I have used to understand and analyse the empirical data. Second, I describe the methods I used to generate that data and reflect on my experiences as a researcher in this particular, often contested, field of activity.

THEORETICAL FRAMEWORK

In this thesis, I take up the concept of boundary objects and suggest that the NCHC functions as a bridge between multiple fields of practice and is thus a useful tool for understanding the competing perspectives of people who plan and deliver care home services in Scotland. I depict the NCHC document as an artefact which links these spheres and the work of contracting as the practice of maintaining that relationship. By using the concept of boundary objects I am able to reveal the different, and at times competing, perspectives which surround care home services for older people and the stabilising work that is undertaken to manage these differences.

Boundary objects by their nature resist definition, though there are several attributes which seem to be common across their varying conceptualisations. According to Star and Griesemer, boundary objects are versatile and can be moulded to local needs. The nature

of their flexibility is such that different participants can extract or ignore elements of the boundary object as suits their purpose. Boundary objects place minimal requirements on the participants, demanding only a 'lowest common denominator' approach from each. This allows each participant to make and use the boundary object according to their own patterns of activity, ensuring some level of autonomous work within the boundaries. These attributes are reflected in Star and Griesemer's formal definition:

Boundary objects are objects which are both plastic enough to adapt to local needs and the constraints of the several parties employ them, yet robust enough to maintain a common identity across sites. They are weakly structured in individual site use. These objects may be abstract or concrete. They have different meanings in different social worlds, but their structure is common enough to more than one world to make them recognisable, a means of translation (Star & Griesemer 1989, p.393).

Star's use of ANT focuses on cooperation in the absence of consensus (Star 2007; Star & Griesemer 1989; Star 2010). This is a fruitful starting point for a discussion of the NCHC text as this document is an apt reflection of these characteristics. It is a product of ongoing cooperation between local government and independent sector care homes, as well as the national representatives of these groups, and yet conflict and resistance also surround this document and its uses. In this thesis, I focus on the power of translation and the mechanisms for disciplining the network which are central to an Actor Network Theory (ANT) perspective, but I also look at the actors who resist that translation and ask questions about the role of that non-compliance. Like Star (2007), Singleton (2011), Dugdale (1999) and Fujimura (1992), I use ANT to focus on dominance as well as divergence. As a result, this thesis shows the invisible work of creating a stabilising device, the black-box activities that are required to maintain that device in the everyday complexities of markets and bureaucracies, and the resistance which it draws from its users.

THEORISING STABILISATION

In order to explore this notion of 'holding things together' and the work that I found research participants do to stabilise the care system, I turn to the concept of translation and two complementary theoretical approaches: Actor Network Theory (ANT) and Institutional Ethnography (IE). In bringing these two disciplines together, I aim to draw out the ecological and spatial relations of power (Allen 2003). Translation is a powerful

activity: it stabilises complex relationships and diverse meanings into a central, shared set of tenets. In this research, stabilising policy work requires the binding together of the activities of national policy actors to local governments — a classic top to bottom binding which applies vertical stabilising tactics. This work also requires the bringing together of local governments and local care homes — a process which more closely resembles horizontal stabilisation. This is not a perfect x and y-axis — it is the uneven terrain of the many vertical and horizontal dimensions of power that are required to produce a system of care. Taking an ecological approach (Allen 2003; Star 2007) is my way of acknowledging the complexity of this policy space without flattening the power dynamics it includes.

Both ANT and IE bring with them a strong internal logic and language system which tends to obscure the underlying connections between them. At their heart, both ANT and IE are concerned with the mechanisms which create stable systems. While ANT is concerned with the horizontal network of relations between the animate and inanimate, IE is concerned with the people at the centre of those webs whose lives are pre-figured by (sometimes oppressive) institutions of power. While ANT often seeks to flatten, IE aims to unpick vertical processes of domination and reification. They are complementary in their interest in stabilisation, and have a shared interest in textual tools of translation. I bring them together here to give an account of the horizontal and vertical processes of stabilisation and to shore up the gaps in their approaches. What ANT lacks in its conceptualisation of power, IE provides many times over through explicit interrogations of power and its trans-local manifestation. Similarly, what IE lacks a detailed theorising of the processes which combine to create trans-local ruling relations, ANT provides in its many detailed ethnographic accounts of these mechanisms.

In ANT, translation theory explains how different entities are brought into a durable relation with one another (Freeman 2009). In explaining this 'durability' of the relationships, translation theory has explored processes of knowledge stabilisation (Latour & Woolgar 1986; Moser & Law 1999; Freeman 2009; Cavaghan 2013) and the stabilisation of an assemblage of actors (Singleton & Michael 1993; Bowker & Star 1999; Ong & Collier 2005). Translation theory, as it is operationalised in ANT, tends to focus on the horizontal dimension of relationships and knowledge practices. It deliberately flattens

these processes in order to map the network and show the role played by a variety of actors.

For the purposes of this project, ANT helps explain how care home providers and local authorities are brought into a stable relationship with one another. Although the language is different, IE has a similar concern with relationships and knowledge practices. In place of translation theory, Smith (1988; 2006) uses the concept of “ruling relations” to articulate the trans-local coordination which drawn actors into a dominant logic and pattern of relationships (McCoy 2006, p.111). IE’s focus is human actors, and their experiences of power and domination. Though it eschews the neutral agency of the non-human actor, IE is still concerned with the role of texts and technologies. Smith’s (1990a) concept of ‘textually mediated social relations’ explores a process in which texts activate readers into their institutional logic, similar to the ‘enrolment’ described in ANT. IE offers a much more vertical notion of translation and focuses on the mass of networked, trans-local, coordinating forces, which subsume individual actors. Within IE, there is an explicit focus on the power of translation to dominate. It offers valuable nuance to the flattened view of translation from ANT.

I pull from both disciplines to strengthen my understanding of the processes of stabilisation. Each uses texts as a central link between communities and focuses on the disciplining power that documents have on people beyond the local site of their creation. In ANT, these texts might be called boundary objects — though ANT scholars go much further in their analysis, using machines and structures to show the power of dominance in networks. In IE, the primary locus of coordinating power is the text and the relations between people, which are thought to be ‘textually-mediated’ (Smith 1990a; Rankin 2003; Mykhalovskiy & McCoy 2002). In the following section, I elaborate on my thinking about stabilisation, showing how these two disciplines allow for an in-depth examination of the stabilisation tactics that make up the policy implementation I observed.

HORIZONTAL STABILISATION

A horizontal view of the mechanisms and moments of stabilisation is useful for understanding the processes that produce a durable set of relationships and a stabilised system of knowledge. This conceptualisation of a flat network allows for a nuanced, and

creative, account of the different kinds of linkages which can be made. Scallops (Callon 1986), classification tools (Singleton 2011), epidemiological modelling methods (Law & Moser 2011) and other boundary objects (Star & Griesemer 1989) are used to solidify the knowledge and assemblage of actors who have a stake in it.

One of the early, and most quoted, explorations of translation theory is Callon's (1986) paper on "the domestication of scallops and the fisherman of St. Brieuc Bay". Callon suggests that "translation is a process before it is a result" (1986, p.19), and proposes that its accomplishment might be composed of the following 'moments of translation': Problematization: a process of problem definition; Interressement: a process of role definition; Enrollment: the activities of negotiation which stabilise knowledge and relationships; and Mobilization: the reifying process in which that knowledge and relationship comes to be a representative shorthand for a complex and instable whole. Callon suggests that these 'moments' constitute the different phases of a "general process called translation, during which the identity of actors, the possibility of interaction and the margins of manoeuvre are negotiated and delimited" (1986, p.6). In this paper, Callon explores the stabilisation of a particular scientific logic and its implications for the relationships between scallops, fisherman and scientists in the French fishing community of St. Brieuc Bay. The concept of translation presented by ANT provides a framework for tracing power relations horizontally. Scallops, fisherman and researchers are assembled across ocean, wharf and lab. The depth of their activity and temporal dimensions in which this activity is situated is flattened to provide a view of the breadth of relationships that have been assembled.

Similarly, Law and Moser explore the way "different forms of expertise" in the 2001 foot and mouth disease crisis "described, explained, predicted and enacted a certain state of the world" (2011, p.34). In this exploration of translation, the authors show that different modelling tools create different knowledges, which in turn offer entirely different pictures of the context of beef production and disease transmission. Each of these knowledge paradigms provided different recommendations in response to the epidemic.

Like Law and Moser, Singleton maps the power of one paradigm over another — in this case focusing on the influence of a new technology in commercial animal husbandry and the world-view that technology creates. Here Singleton takes up the concept of

accountability and the function of legislation in ensuring that farmers carry out safe and ethical practice, suggesting that “legislation must be tinkered with in order to work and it must be sensitive to and inclusive of located practices that are responsive, collective, embodied, materially heterogeneous, and embedded in a history” (2011, p.426). This focus on a tinkering translation of meaning into the “down and dirty” realities of practice (Singleton 2011, p.427) is central to the approach I take here.

There is a concern in Actor-Network Theory with the ways in which stabilisation has an impact across space and time: “the decision-making subject is rendered singular — turned into a specific location. But at the same time, it has also distributed across time and space into future bodies, future conversations and into past points of choice and procedure” (Dugdale 1999, p.130). This conceptualisation accounts for the spread of knowledge, but it doesn’t account for the hierarchies which enable that stabilisation. For that, I turn to Dorothy Smith and Institutional Ethnography.

VERTICAL STABILISATION

I used Institutional Ethnography to stretch Callon’s (1986) four moments of translation vertically. This vertical stretching extends our focus to the subjectivities of the actors involved. To do this, I draw from Institutional Ethnography (IE), developed by Dorothy E. Smith, which makes the goal of research practice to investigate the social organisation of knowledge (Campbell & Gregor 2002; Smith 1990b; D. E., 1926- Smith 2006; Smith 2005; Smith 1990a). Its aim is explication, rather than theory building, and it tends to avoid notions of generalisability or external validity in return for an exploration of ‘what is actually happening’ at a particular scale to a specific set of actors (Campbell & Gregor 2002, p.8). Based on Smith’s work, IE tends to appeal to researchers interested in the ways in which knowledge and power influence the day-to-day organisation of people’s lives (Darville 1995). To quote Campbell and Gregor, “Institutional Ethnography draws on local experiences in confronting and analysing how people’s lives come to be dominated and shaped by forces outside of them and their purposes” (2002, p.12).

For IE, the convergence of dominant ideas which coordinate and constrain people’s activities from outwith their locale is called ‘the ruling relations’. IE argues that institutions shape and condition everyday experience — a process in which certain kinds of knowledge coalesce to become dominant. IE offers an explicit interest in power by

examining the “interface between individual lives and some set of institutional relations” in order to “make visible the ways that the institutional order creates and conditions individual experience” (McCoy 2006, p.109). For example, Tim Diamond’s ethnography of US nursing homes (1992) focuses on the various kinds of work that nursing home residents do in the everyday/everynight. Diamond refutes the conceptualisation of residents as passive by describing the unseen work of cleaning or delivery of medical charts. For Diamond, unseen work also includes the work of grieving, of managing errant bodies, and addictions (1992, p.90). Diamond incorporates the experiences of his participants, including that of Grace DeLong who has advanced arthritis in her hands and limits to her mobility: “Grace seemed continually engaged in a relationships with her hands — one of struggle, quite unlike those who take their painless, working hands for granted. She tried to make light of her shooting pain, in part to instruct the staff how to deal with her hand” (1992, p.89).

Diamond’s account of Grace’ DeLong’s activities fulfills Institutional Ethnography’s notion of work. Distinctions such as paid or unpaid, lay or professional, work are less important to Institutional Ethnographers. Their interest is in showing the ‘effort’ of work. As Mykhalovskiy and McCoy reflect: “Talking about ‘work’ stimulated rich conversation since the term implies forms of effort and intentionality easily recognised by people in their everyday experience. Using the term also helped to establish a way of thinking and interacting that opened up onto a terrain of activity not accountable within prevailing social science discourses” (2002, p.26).

Institutional Ethnography’s conceptualisation of networked activity seeks to connect the individual with the discursive arrangements which surround them. Their view of the term ‘work’ aims to make links between the everyday experiences of the people involved in the research and the discourses, and institutions, which shape that experience. Its first task is to expose a set of otherwise unseen activities, and reveal the embodied experience of work. But its aim in achieving this is to explore the way that individual experience shapes, and is shaped by, the “extended translocal relations of large-scale coordination” (also referred to as the ‘ruling relations’) (McCoy 2006, p.111).

In examining the way individual experience is shaped by these translocal relations, Rankin’s auto-ethnography of her own experience with a patient satisfaction survey in a

Canadian hospitals showcases the work she and her aunt were required to do when they completed the survey form. She argues that patient satisfaction surveys are a tool for the trans-local coordination of lived experience: “[by] placing a new emphasis on customer relations, they support increasingly sophisticated corporate interests that displace what many nurses would see as a proper professional concern about patient care” (Rankin 2003, p.58). In Rankin’s analysis, these documents enrol patients and their families into a ‘corporate’ and ‘profit-driven’ logic of care (2003, p.62) which erases much of the lived experience of patients and their families in the health system. Rankin’s account of the work of completing the patient satisfaction survey highlights the otherwise hidden activities of engagement, the experiential knowledge which is marginalised and the institutional processes which shape her own experience of the hospital’s care. A focus on documents and the work they do is one way of explicating this relationship between individual experience and the coordinating influence of translocal ruling relations.

In this way, Institutional Ethnographers are also interested in the way institutional discourse coordinates and shapes everyday living. Mykhalovskiy and McCoy’s (2002) research on prescription drug use by people with HIV or AIDS explores the ways in which people’s accounts of their decision-making accesses a biomedical discourse. The researchers show the day-to-day activities which people undertake to, for example, “get medications into their bodies— work that can include such activities as preparing and eating a substantial meal, concealing pill-taking from others, and overcoming dread and revulsion” (Mykhalovskiy & McCoy 2002, p.27).

Mykhalovskiy and McCoy alongside Rankin draw attention to dominance of one logic over another, one way of knowing over the embodied and lived experience of the people who are beholden to it. Patient satisfaction surveys, knowledge practices in medical treatment — both have a way of forcing individuals to ‘fit’ the model, to adapt to the ruling relations. Each of these accounts reflects an interest in resistance. Like Diamond’s ethnography, the focus on the everyday work that people do to resist being enrolled is a central part of the networked activity under scrutiny.

STABILISING TACTICS: TEXT WORK, RELATIONAL WORK AND EMOTIONAL/ETHICAL WORK

Smith's concept of 'everyday work' is the field, and focal point, of this research. Smith uses the concept of work in a 'generous sense' to convey "anything done by people that takes time and effort, that they mean to do, that is done under definite conditions and with whatever means and tools, and that they may have to think about" (2005, p.151). Star and Bowker suggest that "the hype of our postmodern times is that we don't need to think about this sort of work any more, [that] the real issues are scientific and technological" (Bowker & Star 1999, p.10). Star and Bowker's project directs our attention to the political and ethical consequences of erasing the day-to-day human and non-human labour — labour which they argue coalesces to build the structures that surround us. In place of the "pyrotechnics" common to ANT, Star and Bower offer an investigation of day-to-day work as a way of "restoring the interlinked and webbed relationships between people, things, and infrastructure" (Bowker & Star 1999, p.10). The methodology used here applies a similar ethos. I focus on everyday work to understand how the current system of care homes is manifest. This research begins zoomed in (Nicolini 2009) and focused on work. Through this lens, I hope to show how the institution of the contract, the stabilising of the care homes system, is made and re-made.

Since work is where this project begins, how might we define it? IE's (Smith 2005; McCoy 2006; Diamond 1992) conceptualisation of 'work' aims to make links between the everyday experiences of the people and the discourses, and institutions, which shape that experience. Its first task is to expose a set of otherwise unseen activities, and reveal the embodied and embedded experience of that work. Its aim in achieving this kind of description is to explore the way that individual experience shapes, and is shaped by, the those ruling relations (McCoy 2006, p.111). Within IE this coordination is also referred to as the 'ruling relations' (Smith 1990b) — which is akin to a concept like 'social structure'. Smith, and advocates of IE, aim to make sociological concepts accessible and meaningful to the user in their everyday circumstances. To that end, the language of IE often transforms common sociological concepts to ensure 'that connections are made between living people rather than abstract concepts' (Dobson 2001, p.147).

A focus on work is a tool for revealing and then exploring the social structures which inform our activity and which our labour goes towards re-producing. Commissioning,

contracting and care management processes are opaque. They operate outside most people's common experience. Though the process of ageing and caring for older people is far more familiar, the structures which organise and facilitate some of those processes are obscured by a haze of public sector and commercial operations. An investigation of the day-to-day work which people actually 'do' gave me a pathway to de-mystify these processes. Smith's interest in work is rooted in her deployment of a Marxist focus on materiality (Smith 1999, p.6). Smith's theorising of 'the ruling relations' is an attempt to see the micro and the macro in the same field of analysis. Smith's interest in the embodied activities of daily living is the lens through which the institution, the discursive landscape and hegemony can be seen.

STABILISING THROUGH TEXT WORK

In ANT and IE, the text, the building — the material world have the ability to structure everyday sensibilities and experiences (Pols & Moser 2009; Winner 1980; Rankin 2003; D. E., 1926- Smith 2006) — they are participants alongside the human actor. Both IE and ANT are concerned with what Smith (1990a) calls the "trans-local" and the ways in which stabilisation has impacts across space and time. Smith and those inspired by her work are particularly interested in the way texts pull people into the ruling relations. IE views texts and readers as active and co-constituting: "the text-reader conversation [is] a process that translates the actual into the institutional, and conversely, the distinctive ways in which institutional discourse subsumes and renders "institutional" the particularities of everyday experience" (Smith 2005, p.105).

This concern with texts is echoed in ANT. For Dugdale (1999), like Smith, control is held elsewhere — trans-locally. This control prescribes the role and limits the autonomy of the text's user "rather than simply putting control into the hands of the user it is a device for distributing control, not once and for all, but as part of many 'modes of ordering' in which it has become a site for on-going negotiation, a site for articulating the work [of others]" (Dugdale 1999, p.131). Dugdale's (1999) interest in 'modes of ordering' (Law 1994 1999) is akin to Smith's concept of the 'textually mediated social relations' and each share Callon's concern with the mobilisation of a dominant perspective — each is, in their own way, trying to account for the sticky coalescence of ideas which somehow come to be common-sense and solid in their pervasiveness and dominance.

An analysis of texts and their activation allows me to understand the way that actors 'activate' these discursive logics in their everyday lives. As Smith suggests, these "text-reader conversations are integral to the ways in which institutional discourses regulate people's local activities" (2005, p.105). An investigation of texts (inscription and activation) enables me to trace social relations vertically through hierarchies of power, e.g. everyday practice, local government policy, markets, Scottish policy, UK policy. It also enables me to trace enrolment, horizontally, of different actors across different geographies into one logic. Texts are a tool of stabilisation; in this research contracts act as boundary objects and bring organisations/people into relation with one another. The text is a technology which codifies the problematization and interessement. It inscribes these relations within a textual document and formalises the process of enrolment and mobilisation of this text through a deliberate period/process of contract negotiation. This first phase of mobilisation is re-articulated — the activities of enrolment are re-made in local settings as local actors carry out the work in which they were enrolled, taking their turn now to enrol local care homes into the NCHC document and its logic.

STABILISING THROUGH RELATIONAL WORK

Boundary objects bridge different communities of practice — different worlds of activity (Star & Griesemer 1989; Bowker & Star 1999; Brown & Duguid 2002; Star 2010). The dynamics of the object itself are often the primary focus of analysis (Carlile 2002; Koskinen & Mäkinen 2009; Bresnen 2010), although I do not think that Star's original intention was to isolate attention on the dynamics of a 'thing' in absence of the work that goes into making and remaking it. In her reflection on the conceptualisation of boundary objects, Star suggests that we should remember to "read [the object] as a set of work arrangements that are at once material and processual" (2010, p.604). In looking at the work practices of these interview participants, I focus explicitly on the activities of translation and stabilisation rather than just the 'object' which is used to facilitate it.

To do this I take IE's term of activation and ANT's term of enrolment to show the way that actors make use of a boundary object in practice and pull others into its logic. These activities locate my analysis in a terrain familiar to ANT and I account for the practices of translation which Callon articulated in his analysis of scallops and fisherman. But I also extend this study of translation to look at the stabilising work of 'creating' the NCHC text — a set of practices which occur 'before' activation and enrolment can occur. Here I use

the terms 'frame' and 'assembly' to show the ways in which the creators of the NCHC built their boundary object. These are different kinds of work in different policy domains (national and local), but each drives towards the stabilisation of the sector. Stabilising work, as Star, Singleton, Fujimura and others suggest, is not uniform. ANT can be criticised for presenting a view of networks where "stasis or stability has been achieved" so that the analytical model "implies a progressive shift from instability to stability or from movement to immobility" (Dugdale 1999, p.131). To avoid this pitfall, I have also focused on the resistance tactics which I understand to be central to the relationships between local governments and care homes in the Scottish sector.

The relational work of these participants, like the text work described above, is located in the wider assemblage which produces the care home system in the everyday. The idea of an assemblage — a loose coupling of different participants — is common within ANT scholarship and is typically used to talk about a network of people and things who are in some durable relationship with one another. To paraphrase Dugdale: 'there is no stasis, but relatively durable connections are possible' (1999, p.131). In proposing the concept of a 'care homes system' as an assemblage, I am arguing for a concept of interdependence as a way of conceiving of local governments, the regulator, care home organisations, people accessing support, their carers, those employed by the care home, the volunteers who work alongside them, the food that is consumed, the medicine used — all these dimensions are necessary parts of the network and none are isolated or independent from the other. In this thesis, I examine one slice of that network — the policy making and strategic planning and delivery of care homes as a service for older people. There is more to this network, undoubtedly, but I take on a slice of it here to showcase interdependence and argue for a re-thinking, not just of the work that goes into it, but of the very nature of the system itself.

CONCEPTUALISING INTERDEPENDENCE: EMOTIONS AND ETHICS IN THE EVERYDAY

As I suggest in my methods discussion below, the emotional prompts in this research have proved analytically fruitful — they have directed me to mechanisms of resistance and power that underpin the rational-technical and relational work I set out to understand. However, in probing these emotional dynamics — I found my theoretical framework lacking. The harmonies of ANT and IE suit the textually-mediated work of policy creation,

implementation and use. They also suit the analysis of a single document, the NCHC text, as a boundary object which draws these three fields of policy practice into relationship. But, neither approach provides the tools to understand the emotional and ethical work I encountered or the conflict between policy domains which I depict in this thesis. To ensure a robust account of these dynamics, I have looked to feminist accounts of emotions (Hochschild 1979; Hochschild 1983; Davidson et al. 2005; Bondi 2002; Bondi 2013) and ethics (Barnes 2012; Mol et al. 2010; Sevenhuijsen 1998; Tronto 1993). Feminist scholars have argued for a re-evaluation of that Cartesian split which was said to separate reason from emotion. Hochschild's research on the sociology of emotions offers a new conceptualisation of the interaction between cognition and emotion and suggests that the 'sentient self' "is capable of feeling and aware of being so" (Hochschild 1983, p.77). For Hochschild, being sentient is both an affective and rational state of being. In her account of emotions, Hochschild refutes "our rationalist culture" through which "we are led to see emotion as an impediment to getting things done and to seeing the world as it really is" (Hochschild 1983, p.75). The Cartesian split creates a polarisation of rational thought and unconscious feeling which "contributes to the notion that to take the affective dimensions seriously is to put the validity or worth of the knowledge generated at risk" (McLaughlin 2003, p.66).

Hubbard et al (2001) suggest that current research on emotions can be conceptualised in three ways: emotional labour (Hochschild 1983), the epistemology of emotions (Jaggar & Bordo 1989; Game 1997) and the sociology of emotion (Denzin 1984; Bendelow & Williams 1998). The first explores the breadth and depth emotional work we do in our jobs and relationships. The second examines feeling as a way of knowing the world. And the third examines the feeling rules which govern our presentation of emotions within particular social contexts. I take inspiration from each of these approaches in my research, taking up the sentiment that "to talk seriously the role of emotion in research is to strengthen the research, for all aspects of the process are connected to emotions" (McLaughlin 2003, p.69).

This integration of the rational and the emotional is echoed within the canon of scholarship in feminist ethics and care. Within this literature, moral judgements about 'right' and 'wrong' are situated and contextual — they draw on past experience and the moral reasoning of an emotive subject located with a particular set of circumstances. In

this way, care ethicists (Tronto 1993; Robinson 1998; Sevenhuijsen 1998; Held 1993; Barnes 2012) unsettled universal assumptions about moral duties and argue the need for a relational sense of justice — one that is constructed through context as much as universal rights. Tronto argues that “on the most general level, we suggest that caring be viewed as a species activity that includes everything we do to maintain, continue, repair our ‘world’ so that we can live in it as well as possible” (1993, p.103). The broad focus of care, as a practice which includes all aspects of human activity, is reinforced by Robinson who writes that “this is not an abstract ethics about the application of rules but a phenomenology of moral life” (1998, p.31). Similarly, Sevenhuijsen suggests that “this approach makes it possible to acknowledge that care takes place in all kinds of contexts, from child-rearing practices and intimate relations, to social services, education and political deliberation” (1998, p.22). This is a political framework, applied to international relations and welfare policy as much as it is used in the interpersonal relationships involved in paid and unpaid care work.

Together these literatures offer a relational, dependent, contingent, sense of humanness. In so doing, they explicitly refuse a conception of the individual as isolated and autonomous. As Barnes suggests, interdependence should be within a relational ontology, which “calls attention not only to the particular, personal needs of individuals, but also the socio-political context in which those needs are produced and experienced, and to the processes by which difference and consequence exclusions are constructed” (2012, p.31). In the empirical chapters that follow, I draw attention to the way emotions and ethics function in the production and re-production of the care home system, suggesting that they underpin the rational and relational stabilising tactics that I encountered.

METHODS

IE does not provide the researcher with a prescriptive research programme. Instead, it advocates an inductive approach that allows for the emergent and iterative nature of investigation. That is the approach I take here; as Campbell and Gregor suggest:

We want to study things that are being lived, experienced, and concurrently or subsequently, talked about. We want to understand how they happen that particular way. We find and use data to discover material connections between what actually happens to participants in a research setting and what triggers those particular actions or events

(2002, pp.69–70).

While the use of IE demands an exploratory approach, there are constellations of a sort within this programme which might help guide the researcher in their journey. First, IE pays particular attention to beginnings. The researcher is encouraged to account for their own standpoint and to identify their relationship with the inquiry. This helps to identify the 'problematic', a term in IE which is used to symbolise the puzzle that the research sets out to understand. Then, there is usually a period of document analysis, interview and observation. In the following section, I outline the methods I used to generate data for this research and reflect on the process of collecting, analysing and sharing that were central to the production of this thesis.

RECRUITMENT: RESEARCHING LOCAL GOVERNMENT

My focus in undertaking this research was to explicate the organisational dynamics which make up care home delivery in Scotland. I approached interviews with an interest in work and the tools that people use to do that work. As the research design was emergent, I brought a high level of flexibility to the structure of the interview, viewing them more as conversations (Kvale & Brinkmann 2009). Given the paucity of literature on planning and managing care homes, particularly in the Scottish context, I was reliant on the participants in this study to elucidate the system and link me to others in the sector who could add to my growing understanding of the system. As such, I felt I had very little existing knowledge, much less practical understanding, to bring to these conversations.

I found recruitment particularly challenging in this project. My original research design was based on the comparison of three local authorities. When I began to approach the selected local authorities, I found that local governments have vastly different structures for managing and carrying out research. Some local governments have a research officer and protocol in place for engaging with researchers. Others have no such structures in place to facilitate a researcher's interest in their work.

Even in those councils that provide a contact point for doing research, the processes of gaining access and approval to do research are unclear. When I approached one of the participant councils, I was invited to a meeting to discuss my research. When I arrived it became clear that there was a lack of clarity with the research officer as to whether I was

there to interview them or have a conversation about gaining approval from the organisation to do the research. During this conversation, I was also asked whether my interest in this particular council was due to a recent high-profile care home closure. Though I hadn't heard about this particular incident, it highlighted to me from the outset that this research was encroaching on sensitive territory.

In order to gain research access and approval to this council, I provided an outline of my planned research, and the scope of participation sought from the commissioners and contract managers in the council. Since my research did not involve interviews with people who access support or a review of any confidential service user information, the approval process was fairly 'light touch'. An approval from the research officers provided me official access — more importantly, it also helped me to secure contacts for the research. I relied upon their knowledge, and goodwill to share that information, in order to gain access to key participants in the council.

Local governments are opaque organisations. Organisational maps exist which show the positions of people in the council and the name and contact details of the individuals who fill those roles. These are not available to the public and an investigation of any of the websites for councils that I hoped to work with on this project revealed a lack of any specific organisational details. Not only were there no names for people in the council, there was no positions or roles. There was no central contact for commissioning. There was no central contact for older people's departments. My fieldwork has provided me with a map of some of these positions and the people who fill them — but much of what I learned was unique to these local authorities. There are some commonalities between local governments, but these are local configurations with their own histories and resources.

Other interview contacts were gained through a process of snowballing. Snowballing took two different forms. Snowballing might occur within an organisation such that a participant might link to someone else in their department or in a related department which worked on the strategic planning of care for older people. At each interview, I would ask participants to tell me who else they worked with — who supported their work — and who depended on their work. These details were often mapped (see section on mapping below). I used maps as a tool to 'snowball' additional participants for this

research. Once I was able to secure a few interviews and some good will in the sector, recruitment through snowballing became much easier. In the end I was able to carry 31 one interviews (which I discuss further in the sections below).

RESEARCH POSITION

Hubbard and colleagues suggest that as researchers “we tend intuitively to screen ourselves out” (2001, p.120). For me, this phrase captures a process of knowledge production common within research in which the feelings of the researcher, and perhaps that of the participants, are ‘screened out’ of the ‘data’ that is presented in the finished research outputs. In this research, my emotions in the field ‘signalled’ that there was a dynamic between me and the participant which was worth exploring. I have used them, as Hochschild suggests, as “a clue” (Hochschild 1983, pp.28–34), often directing me to a power dynamic or to a more nuanced and empathetic way of seeing the work that I encountered.

Hochschild suggests that emotions are a way of seeing the world: “like hearing or seeing, feeling provides a useful set of clues in figuring out what is real” — in fact, she goes on to suggest that “taking feelings into account and then correcting them may be our best shot at objectivity” (1983, p.31). This assertion is echoed by other sociologists in the field, such as Hubbard and colleagues suggest “knowledge is not something objective and removed from our own bodies, experiences and emotions but is created through our experiences of the world as a sensuous and affective activity” (2001, p.126; cf Game 1997).

An empathetic stance (Jones & Ficklin 2012) is how I describe my position in the research. For me, it involved making space for my feelings and the feelings of the research participant. These were not therapeutic interviews and they did not provide the kind of productive reflective space that others have claimed resulted from their research (Munro 2012; cf Bondi 1999). In fact, these interviews tended to prompt emotionally charged reactions and few opportunities for productive reflection or closure. These interviews often felt like they had opened a wound and I had few resources on offer to mitigate that experience. My recollection of the fieldwork is dominated by my memories of a few challenging interviews in which emotions seemed to run high and dominate the interview space. Participants in these interviews seemed to be angry — not with me — but with the

system of care and the national care home contract. The anger and frustration that surfaced in these interviews has stayed with me. It was provocative in so much as it promoted me to re-think this field of practice and examine the emotional dimensions of these interviews with greater scrutiny.

There was a time when I was unsure what to make of my fieldwork. I couldn't understand why it was proving so difficult. I had been advised by my supervisor that participants might thank me for the opportunity to talk through and reflect on their practice — that they might value the interest in their work. But everything that I was experiencing ran contrary to this expectation. These participants didn't seem happy to talk with me. On the benign end of the spectrum there was a sort of curiosity about my interest — and those interviews often proved challenging because so much of the participant's work was implicit and commonsense to their field of practice. On the more raw end of things, there was a sense of frustration at the questions being asked. Sometimes I interpreted this as an irritation that I didn't know enough about the context or the NCHC document. At other times, the frustration was directed at the document, the Local Authority, the Care Inspectorate, the 'other'.

In approaching the field, I wanted to accept the version of events presented by the participants in the study. This is a political context and there are ideological and value-based debates around marketisation of care, which I had some proximity to (Pollock 2004) and which appear in some of my own research (Stocks-Rankin 2008). However adopting a more neutral stance was important to me. If I was going 'seek out sites of conflict' as I proposed in my research design — then I needed to be open to the experiences I encountered. In my approach to interviewing, I adopted an empathetic stance as a way of aligning myself to the perspective of the participants in the research. This research sought to map the interconnections between the lived experience of small group of research participants and the system of care which they build through their work and practice. The methodological approach, as described above, was inspired by Institutional Ethnography's emphasis on explication over explanation. To that end, I approached my fieldwork with a desire to align myself with the participant in the research and honour the worldview they presented in our conversation. By aligning myself to the participants in the field, I aimed to act as a "learner" in the research environment (Blaikie 2009). This value-position is adopted with the recognition that my knowledge is

embedded in my own experiences and values and cannot be separated from these experiences.

Ontologically, this approach challenges the idea of objective truth and immutable knowledge. This can be problematic for some (feminist) scholars, particularly in social policy where there can be a normative idea of progress and improvement (cf Church 1995). These perspectives tend to criticise a more constructionist approach as relativist and disconnected from the very real social ills that are observed by the researcher. In response to these hypothetical claims, Bacchi argues that objective truth may be unattainable, but that it is exactly this knowledge which “produces the obligation to debate substantive social visions” (1999, p.63). As such, she claims that discourses can be understood, challenged, and changed through the deconstruction of the values/assumptions which underpin that practice, and by further situating that it in the historical context of shifting socialisations.

INTERVIEWS: REVEALING DAY-TO-DAY WORK

Interviews focused on one central concept: work. The bulk of my conversation with participants focused on day-to-day practices that make up their professional paid role, their rationale for doing that work and the tools involved in that work. Smith uses the term ‘work knowledges’ to focus attention on “a person’s experience of and in their own work — what they do, how they do it, including what they think and feel” (2005, p.151). This allows the researcher to focus on the participant’s own experience as a form of expertise.

I went into my first interviews with a broad range of topics: work, relationships and tools/texts. I would write these themes in my notebook in advance along with a set of questions such as: “What would a typical day’s work involve?” “Who do you work with?” and “What kinds of tools do you use to do this work — what helps you to accomplish your day-to-day tasks?”. In practice, I usually began the interviews with a question about how my interviewee came to be doing that particular job. I was interested in understanding why people had chosen to work for the local authority or a care home. Some participants were more willing to talk broadly about their work and careers. With others, I sensed a need to make the most of the interview — to be efficient. I began to tailor my interview

style to suit the context of the interviewees work and the interpersonal dynamics that arose in the interview. I was often conscious of being a novice in the area and I found myself reaching to 'prove' that I had some knowledge of their work pressures and 'earn' the right to ask my questions about their job.

For example, when asking about a typical work day, participants would often quip that 'there was no such thing' — 'that their work was different every day'. As my fieldwork progressed, I found myself asking the same question but with the throwaway comment that 'I know there's no such thing as a normal day'. This is a seemingly innocuous example, but I think it reflects some of the small ways I began to adapt to the context of my research.

While many people were happy to speak to me and make time, their work pressures were such that I often felt that there was little room for error in my conversations. The relationship between the interviewer and interviewee has been described as a parasitic one (Hubbard et al. 2001, p.129). I felt I had very little to offer the participants in this project. I could not promise to 'solve' any of the concrete problems with which they were faced. I was confronted with issues about the regulatory system, the partnership working between care homes and the council or between the council and the NHS. I heard about a range of long-standing political issues in the sector as well as some of the interpersonal dynamics that surround their work. I heard about complaints against particular care homes and 'chronically inept' care inspectors or social workers.

As my fieldwork progressed it became apparent that there were long-standing, highly-charged relationships in the sector. In asking questions about this work, I was opening up some of these debates again. Without clear outputs for this project, I found myself floundering a little. My only recourse was to seem knowledgeable and assert some sense of capability. I learned a great deal about the sector as I progressed. At first, I often had to ask for acronyms to be explained or for more detail about the purpose and configuration of key meetings — aspects of their work which were taken for granted and which I had no knowledge. Reading back through my field notes, I can see where I've made nervous reflections about 'pretending' to know. There was much in those first few interviews which was new to me. I felt I could only ask for clarification so many times and often pretended to know more about the sector than was actually the case. As my fieldwork progressed, I

started to note that “I am learning!”. These were small victories, but I began to feel more certain of myself as I was able to see some of the key themes emerge.

INTERVIEWS: MAPPING RELATIONSHIPS

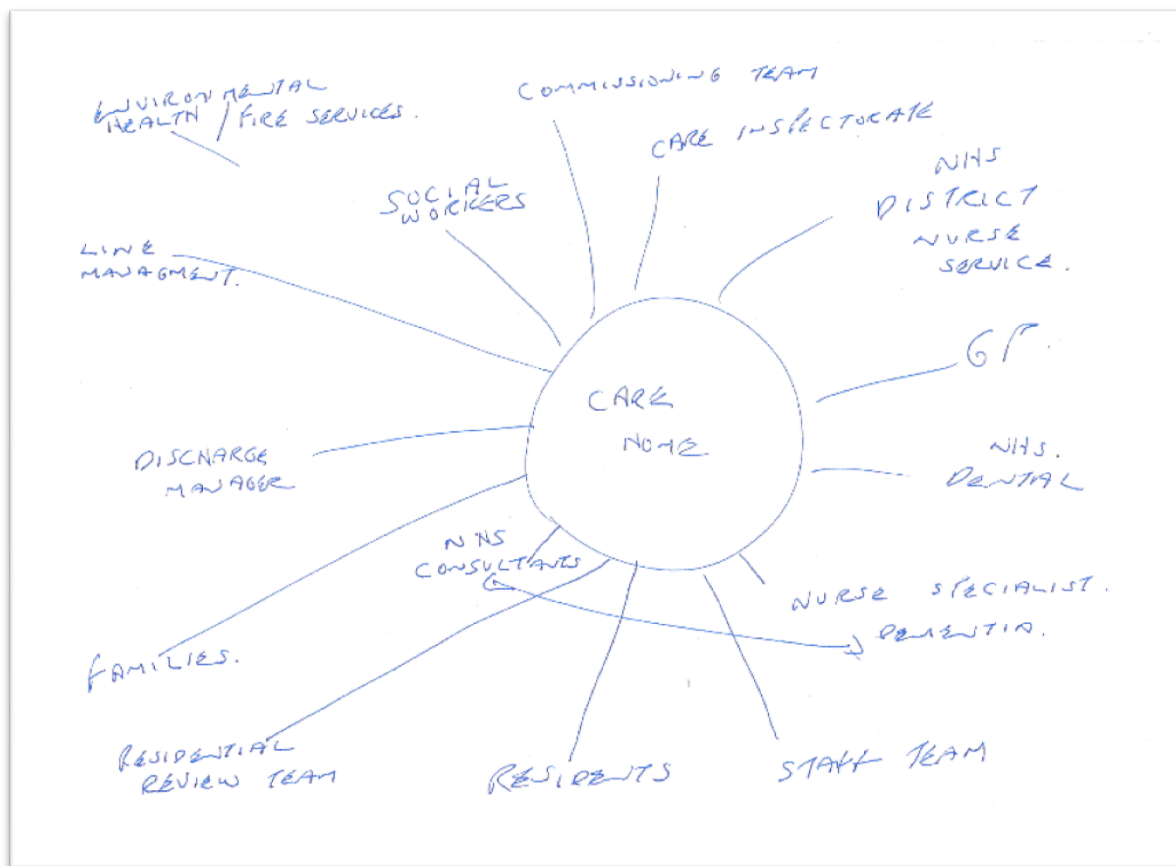
In researching the broad concepts of text, work and relationships, I used map-making as a tool to prompt conversation about the context of a participant’s work and the relationships in the sector that were meaningful to them. This approach is part of a loose grouping of methods called creative methodologies which draws on film making, photography and other creative media to facilitate the research process (Gauntlett 2011). One example of this approach is the map making used by Pinder and colleagues (2005) in their review of care pathways in the NHS. In asking participants to draw their own map of a patient’s journey through their treatment, a wealth of nuance was found to exist within the standardised process of the ‘official’ pathway map. As Pinder and colleagues reflect:

What had started out as a one-size-fits-all model of professionally delivered care turned out to be dependent for its success upon a complex (and unmapped) network of relatives, friends and informal carers in the community. As soon as the contingencies of patients’ lives were overlaid onto the hard rectangles and straight lines of the pathway, the illusion of authoritativeness began to crumble, prompting an exasperated ‘It’s quite complex, it’s supposed to be simple’ (2005, p.768).

I found a similar pattern of reflection and realisation when I asked interviewees to make a map of the relationships which were most important to their day-to-day work. Participants tended to put themselves or their organisations in the middle of the page and work round in a circle indicating various roles within their workplace as well as external organisations and people with whom they interacted.

This map-making tended to encourage a kind of reflexivity in the participants’ account of their relationships or their work. The nature of the relationship, whether it was ‘close’ and important was often articulated through this process. For example, one participant noted their late addition of ‘older people’ on to the map — an observation that prompted the two of us to reflect on the dominance of commissioning and contracting processes in the interview and the implied absence of older people in the planning of those processes (see Diagram 2).

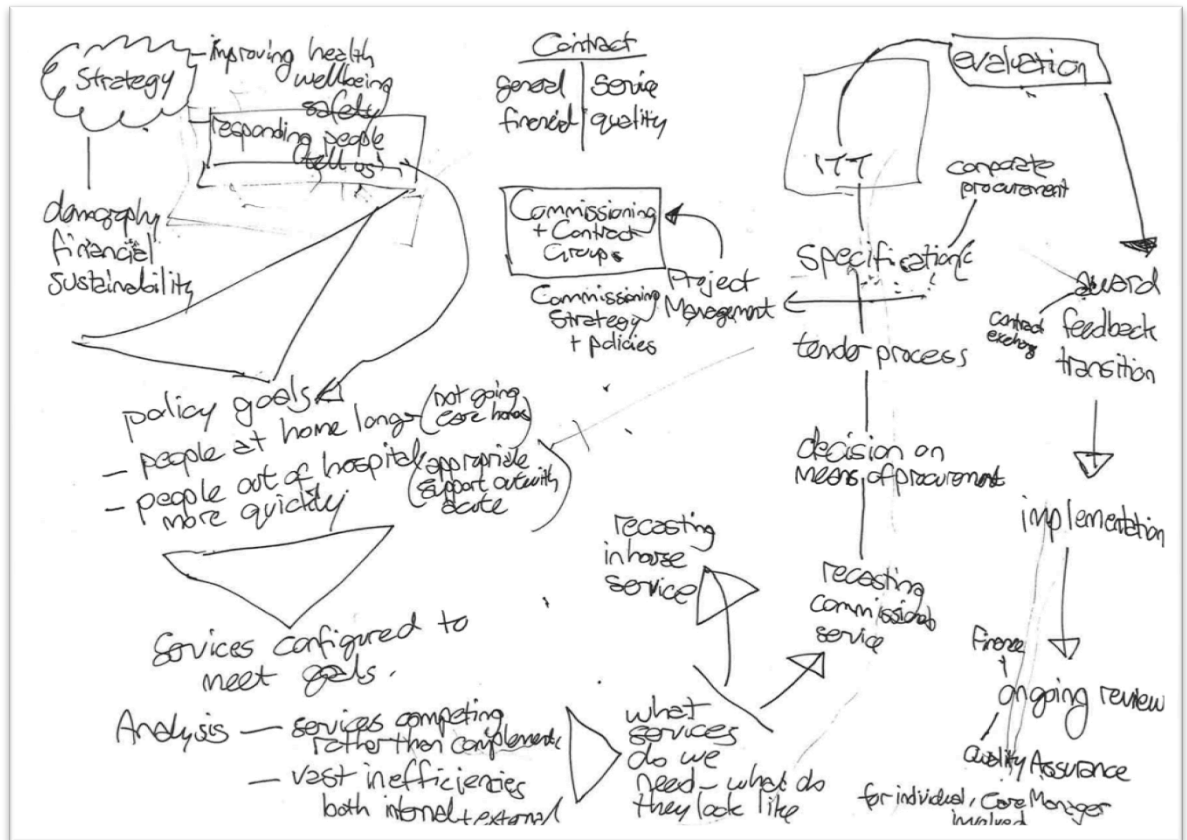
Diagram 2: Participant's Map of the Social Care Sector



There is an additional element of the mapping which was very successful in some interviews and less so in others. Like the relationship mapping described above, I also asked participants to map their workflow and depict the processes which make up their day-to-day work. This was challenging for some people as their work processes are often too complex to visualise in one picture or diagram. I also found myself pressed for time in interviews where I tried to use multiple mapping exercises. In some cases, however the map was highly insightful. I include an example of one of those maps. Diagram 3 is a map of the participant's representation of their work as a commissioner for social care. It aptly reflects the complexity of the commissioning process and deviates both in detail and design from the model produced in the procurement guidance (See Diagram 1 in Chapter 2).

By mapping the sector from their vantage point, I was able to picture, literally, the sector from within the system itself. It gave me an opportunity to align myself to the participant's vantage point and opened up the space for dialogue about their work and their practice in ways I could not have foreseen. The limits to my knowledge became an advantage as I was able to see the sector with fresh eyes (though admittedly some of this freshness dissipated as I gained my own expertise over the course of the fieldwork processes).

Diagram 3: Participant's Map of the Commissioning Process



The mapping exercises also helped me to do some snowballing and find new participants for the research. As the research design was emergent, I was dependent on the goodwill of people in the sector to find new participants. By mapping the relationships which were meaningful in their work, I heard stories about 'good people' in different parts of the organisation and sector. At the end of the mapping exercise I was able to ask the interviewee if they could put me in touch with some of these individuals on the map.

Mapping is more than a visualisation of the sector or a way to snowball new interviews — this process facilitated a different kind of interview dynamic. Asking participants to visualise their work process and/or relationships placed them firmly in the role as experts. Interviewees shed light on specific aspects of their work in relation to the system as a whole. For Pickles, “recognising the socially constructed nature of identity claims (our concepts, categories and practices) is a first step to a deconstructive retrieval of the other possible worlds, spaces and mappings” (2004:18). Pickles suggests that the cartographic imagination is a tool we might use to render the implicit, explicit. He looks to Harvey who claims that “all this talk about ‘situatedness’, ‘location’, and ‘positionality’, is meaningless without a mapping of the spaces in which those situations, locations and positions occur” (Harvey, 2000:111-12). Theoretically, this process helped me to clarify the ways in which the system is local — built up from the particular relationships, meetings, processes, texts, demographic data, and people in a particular place (e.g. local authority area). It also helped me to clarify where the system operated at a macro level — national forums, national advisory groups, national policy, national pricing structures and a national contract to bind them all together. The interplay between these fields — the local and the national — is a central contribution of this thesis. Mapping, like the interview process was as much about analysis as it was the generation of new data (and new contacts).

CONFLICT IN THE FIELD

In the following section, I draw out one example of the emotional dimensions of my interviews and the salience it provides to my analysis. In this vignette, I depict a conversation about legitimacy which was manifest over the consent to use interview data in this thesis. The conflict about this data was highly escalated, involving the threat of legal action, numerous emails and one fact-to-face meeting to negotiate and discuss. In recounting this story from my fieldwork, I aim to highlight the emotional nature of these conversations, first, to draw attention to this theme in the research, and second, to show the value of exploring (rather than ‘screening out’) emotions in the field.

In the spring of 2012, I managed to secure an interview with Joe, who had been recommended to me in some of first interviews as a vocal advocate for the independent sector in Scotland and a ‘good soldier’ for Scottish Care (the representative body for

independent sector care providers in Scotland). As with most of the participants in this project, finding their contact details was challenging. By the time we had our formal conversation, I had already invested months of (invisible and unconscious) work into our meeting. Upon arrival at his home office, the interview had grown to include Martha who worked for another care home organisation and had been invited by Joe, the original interviewee. Together we talked for two hours about the NCHC document and their relationships with local government, COSLA, Scottish Care, the residents in the care homes, staff and each other. In reviewing the transcript, I can see that I struggled to assert myself in the conversation. My first question, which sought background on their work and how they came to be working in the sector, led to a twenty-minute discussion between them. This was the pattern of our conversation, and I remember resigning myself to this dynamic given that they both seemed to have so much to say. That first twenty minutes alone includes material on their indictment of local authorities for a failure to change, the dominating role of certain organisations or people in the sector, their own efforts to create meaningful change — all of which was charged with emotive language. The interview progressed in this vein for two hours. As I sat reflecting on the experience on the train home, I felt I had been dominated in the interview by their collective need to ‘vent’ their frustrations. I was tired and upset, in part because I felt I had lost control of a valuable opportunity to ask questions of their work, but in truth I think I was exhausted by their narrative and my role as the passive recipient of their anger.

When I finished transcribing the interview, I sent a copy to Martha and Joe for their records and for validation of the material we’d discussed. Their response was unexpectedly strong. I received a voice mail from Joe a few days later which expressed dismay at the material I’d sent them, vehemently denied my use of the data, and threatened to sue me if any of the material appeared without their consent. I was shocked by the reaction and drafted an email reply which assured them that the data would not be used. I asked them if they would like to discuss the issue further and ensured them that I was available for discussion at any time. After another follow-up email and phone call, we met again. Through this conversation, it became clear that Joe and Martha were surprised not by what they’d said in the interview but how it looked. Over the course of our hour-long conversation, I realised that the issue was the unpolished presentation of the interview conversation. It looked and sounded like speech, rather than highly edited, coherent, text. From their perspective, this made them look less educated, less articulate,

less legitimate. In the end, we agreed that they could verify the presentation of specific excerpts of the interview which are presented in the thesis. I told them that I wanted to be sure to tell the story of how hard they work and the emotional, caring, aspects of the work they do. 'You're not machines' I said and 'I want to make that part of the system more clear'. Martha replied by saying that she too thought that was important.

I have suggested that legitimacy is at the heart of the tension between me as the researcher and Martha and Joe as managers in the care home sector. I have taken the time to show this process of data generation and analysis to make explicit the process by which I come to the claims in this thesis. In asking questions about the NCHC text, I had placed myself between the care home managers and the local authority/Care Inspectorate nexus which they work to resist. I experienced a kind of resistance from Martha and Joe — first in their anger and frustration in the interview and then in their vehement protectiveness over interview data. However, I don't think it was directed at me or the interview per se. As I show in Chapter 6, care homes have a story to protect — a story which reveals something about their legitimacy within the sector. My interview posed a threat to this legitimacy. It had the potential to cast them in an unfavourable light — not as people who resist, who have opinions about the structure of care and are emotionally and ethically committed to their work, but as unpolished and incoherent, thus de-legitimising their claims for change.

DATA ANALYSIS

The iterative approach I have taken reflects my need to carry out a robust, grounded, analysis that respects the individual's perspective, the complexity of their work and the system that work creates. I noted, above, that this chapter reflects the tracking back and forth between theory building and the generation of evidence. In this section on the analysis of data, I articulate the 'call and response' this iterative approach required — not just in a 'phase' of data analysis but over the duration of my project, beginning in fieldwork, continuing through transcription and coding and on into participant validation, knowledge exchange, and writing.

My approach to analysis draws on the principles of grounded theory (Glaser & Strauss 1967; Corbin & Strauss 2008; Charmaz 2013). As a 'kind' of analysis — 'grounded theory'

is the simplest descriptor of the quality of qualitative work that has been carried out. But, grounded theory is a broad church and many social science researchers claim to have conducted a 'grounded' analysis of their data. In my experience as a research student, grounded theory has become a proxy for light-touch thematic analysis rather than the thickly descriptive, data-driven and theory-building work that was begun by Glaser and Strauss in the 1960s (Glaser & Strauss 1966).

To be more specific about the 'kind' of grounded theory I have done, I suggest my analytical approach is narrative in focus (Diamond 1992; Maynard-Moody & Musheno 2000; Czarniawska-Joerges 1997; Czarniawska-Joerges 2004). I have retained a strong fidelity with the data from individual interview participants, referring to them by an anonymised name, organising the writing material around their perspectives and using large segments of the interview data to provide detail to claims I make in this thesis. Through their accounts, I focus on particular narratives from our interview conversation and use these 'stories' to build up an analytical picture of stabilisation.

Although I adopt the spirit of grounded theory by focusing on data as the driver for theory-building, I note that my approach is less inductive than traditional approaches to grounded theory, adopting a more abductive approach — tracking back and forth between the data that was generated and my own theoretical tools (particularly IE which I used to direct my approach to data generation). Charmaz notes that grounded theory is “a method of explication and emergence. The method takes a systematic, inductive, comparative and interactive approach to inquiry” (Charmaz 2008, p.156). My approach chimes with this thinking. Many grounded theorists, and Charmaz (2006) in particular, suggest that this is a more honest accounting of the research process as researchers are often negotiating their own assumptions in the field and then again through their analysis. Reflective research practice (Service 2012; Bondi 2002) can support a robust unpicking of these assumptions and I have used it here to do just that.

For me, data analysis began in the field. At first, I made long reflective notes after my interviews — sometimes typing up 4000 word reflections which developed preliminary themes and tested my assumptions against the data that was produced. For example, the following excerpt from my field notes shows the analysis I was doing in the early stages of the process. The word “translation” was used repeatedly in one of my interviews. In this

passage, I grapple with its meaning for this participant and whether it maps on to my own theoretical knowledge of the concept.

The concept of translation comes up quite a bit in this interview. It's used to describe the ways in which knowledge or information is moved from one group of people to another. Sometimes it's used to indicate that knowledge/information will be transformed or adapted. Sometimes it's used to indicate the way a policy or guidance will work out in practice. It's interesting that this concept was raised. Sometimes an interview seems to have a key word. For interview 3 – it was 'trust'. For this interview it's 'translation'. What's more it seems to be used in the same way I would use it theoretically. This seems to suggest that the theory is quite close to the real world understanding of the concept — maybe the theory really works.

(PhD field notes, 9/9/2011)

Other field notes reflect a similar effort to grapple with the context of the interviews and my own response to the data that was being produced. In the following excerpt, I reflect on my empathy for the participant and my surprise that I wasn't taking a stronger position on the commercial mechanisms used in the Scottish social care system.

Is there something useful about empathy in interviews? I seem to be able to see things from [participant 3]'s perspective – even though I find the market principles of care provision a bit antithetical. Maybe there is something sort of pragmatism at work here. I seem to be happy to accept the parameters of the system as they are presented to me. But I also worry that I'm being co-opted by their rationale. Surely there are other ways of doing this work? Surely the market does not need to win out in as much as it does? Maybe I should have a stronger sense of the alternatives? Maybe I need to have more conversations with activists, etc.? Also, why on earth did I ever consider myself to be an activist – I clearly have no real idea how this system could be alternatively organised.

(PhD field notes, 22/7/2011)

These reflections were a common part of the early interviews I conducted. Given the absence of practice-focused literature on the organisation of social care, I went into the field with a large blank slate. These reflections are my attempts to come to grips with the detail of the day-to-day work that produces the care home system. For example, in one

passage I try and work out how contract managers work with different service areas in the council.

There is a sense that the Contracts Team has to manage a variety of strategies pertaining to different client groups as well as the different dynamics inherent in multiple management teams in the Council. Since services are organised by client group, the people who work on service planning vary from service group to service group. It seems like the Contracts Team must negotiate these various demands. But, it's Contracts that help arrange the contract (the service specification?) and Contracts that deal with the maintenance of these contractual relationships.

(PhD field notes, 9/9/2011)

These reflections give an insight into my approach to analysis. I developed a sense that I was taking an empathetic approach early on. I also started to think about translation at that time too. But I was also thinking about regulation, efficiency, space, time and trust (to name a few). I was developing ideas and making connections across interviews, but I didn't begin to narrow the scope of my analysis until much later in the process.

Once the bulk of my interviews were complete, I began the process of transcription. This was an unexpectedly challenging phase of the research for me. Transcription is a slow process. It is thought to add to the analysis phase as it allows the researcher to experience the interviews again (Ross 2010). It also creates a necessary distance between the researcher and the data — creating an artefact of the research interview in the form of a text which can be abstracted from context, cut up for code and used. For me, the transcription process was difficult in two ways. First, it brought a microscopic focus to the interview experience. I would listen to the conversation in slow motion and translate the recorded word into a written text — sometimes going back several times to capture words or phrases that were said too fast for me to catch the first time (technical terms and abbreviations were common parts of the interview). For me, transcription served to magnify the emotional weight of these interviews.

Transcription was also difficult because it abstracted the content in a way that made me uncomfortable. There were emotional nuances to this material which I could not capture and conflicts erupting between me and the interviewees which had the process of

transcription at their heart. Of course, there were some options available to me — such as discourse analysis — to help capture additional details in the transcription, but I found them too labour intensive and wasn't clear they would help me get at the depth I wanted. Adding in markers for a pause or verbal emphasis seemed to add to the clutter between the interview experience and me. I was reticent to commit to that approach, particularly given the theoretical framework I was applying (IE is a pragmatic research discipline — it may draw from discursive approaches but its ethos is more closely tied to the experience of the interview rather than the science of linguistics).

The challenge, then, of capturing the experience of the interview would depend on my field notes and the written analysis I was developing. What was harder was the way transcription re-immersed me in the conflict of the interview encounter. In slow motion, some of the dynamics were emotionally labour-intensive to work through. In the end, I found both of these challenges could be ameliorated with some outside support to transcribe. I found I could gain necessary distance from some of my more difficult interviews, and, I now had additional time (and emotional capacity) to reflect and analyse through journaling and knowledge exchange activities (described below).

I used Nvivo to code the interviews. As I note above, I find coding can be an abstraction from the data. Coding can be used to develop isolated fragments of data, abstracted from the interview context and added to written analysis as evidence. The co-constituting nature of analysis, which is dependent on and rooted in data, is often missing in this use of coding. I find I am uncomfortable when participants' narratives are used to 'evidence' a researcher's theory. The power dynamics are too unbalanced in this use of data. I strive, like other feminist researchers, to pay attention to context and ensure my analysis is not dis-located from the people who helped me to produce it. This chimes with feminist epistemology and its interest in knowledge claims — in who voices are heard and whose voices are silent (Harding 1987, Rose 1997). For example, Harding suggests that "reflection on how social phenomena get defined as problems in need of explanation in the first place quickly reveals that there is no such thing as a problem without a person (or groups of them) who have this problem: a problem is always a problem *for* someone or other" (1987, p6).

In response to my concerns about coding, I used this phase as a way to re-engage with the interviews. It was important to use coding as a way to gain an overview of the data as whole. But, I refused to divorce the data from the individual narrative (which I discuss further in the 'presentation of the thesis section below). For me, coding was more a process of validation than one of initial analysis. Much of my intuitive sense of the interviews was 'confirmed' through the process of coding. It became more important at this stage to create a roadmap through the data. When I was immersed in listening to the interviews, I felt I had a good sense of the themes and how they fit with my thinking on the contract and the sector — but stepping back and looking at the holistic whole of my project often left me feeling overwhelmed. Coding was one way to make sense of these themes at a macro level of project analysis, rather than interview-level analysis.

In working up the a series of codes for each interview, I would read interviews within the Nvivo software programme and highlight segments of text that had meaning to me as a researcher. Common codes include: "managing the market", "emotive", "differences between local authorities", "responsibility", "power", "hard work", "working with the text", incentives and penalties". The development of these codes was based entirely on the interview data. I did not develop a list of common themes from the literature, which is a common approach to coding (and inappropriate here given the difference analytical approach that previous researchers have adopted). Instead, I was led by the data and my interpretation of it — working up codes interview by interview to build a picture of the data as whole and the kinds of narratives it included.

Grounded theorists talk about 'saturation' — a transition point in the coding process where fewer new codes are added and data is more often categorised within existing framework. Given the diversity of the participants in this project, I reached small points of saturation within groups of interview participants (e.g. care home managers or contract managers) but did not reach a saturation point across the whole of the data collected. I stress this point to reflect the complexity of the data that was collected and underscore my rationale for limiting the data presented in this thesis.

Coding was also useful for confirming my sense of the emotionality in interviews. As I began to layer in emotional codes onto the substantive codes like 'managing the market' or 'managing relationships with care homes', I began to see the emergence of a more robust

accounting of my emergent analysis. This was a significant turning point for my research. Emotions had been a central feature of the project (as I show in the fieldwork notes above), but I was not sure I could robustly account for them across the interview data. In fact, 'anger' and 'frustration' were features in several of the interviews. More importantly, these kind of 'negative' emotions featured more heavily in one group of interview participants (care home managers) — a finding which helped me to drive forward my analysis and supported a new phase of theory-building.

As I have highlighted, I found the process of interviewing to be an unexpectedly emotional process. I was unprepared for the conflict I would find in the sector and the sense of helplessness I would experience in hearing these stories. In my case, writing and presenting my preliminary findings prompted self-reflection and were the primary spaces for honing the analysis I present here. In order to produce the analytical product (and artefact) that is this thesis, I spent seven months writing intensively, which resulted in the rough drafts of Chapters 2, 4, 5, and 6. The analytical arc that I present in this thesis came to me early on. I knew that there was a story to be told about conflict and translation, but it took time to craft a thesis that was respectful of the micro-practices that happen locally and still draw attention to a national structure of coordinated activity.

Connecting the micro with the macro was a tricky analytical process, particularly if one subscribes to the ethos of grounded theory as I have done. It was made more difficult by my desire to show the trans-local nature of this translation process — the way policy was created, implemented locally and used by providers. Working vertically (micro to macro) within each chapter and horizontally across the thesis (creating, implementing, resisting) was a challenge. For me, it required an attachment to the data and a refusal to 'apply' a theoretical framework 'onto' that data. There is pressure, particularly within time-limited research projects, to reach for the theory and make the data 'fit'. It makes for an easier read — there is familiar terrain for the expert reader — and a thesis which contributes to existing academic conversations, pushing and testing theoretical terrain which has already been developed. As I note in my prologue, I'm more interested in the people doing this practical organisational work and feel a sense of responsibility to improve the system itself — for people accessing support and practitioners. It meant that I took a different tact. In focusing on building theory up from the data, I worked hard to refute some of the assumptions within those theoretical frameworks (as I describe in the theory section

above). It also meant that my analysis begins with description and data — deliberately so. This thesis is a re-description, — a way of seeing the familiar differently, and it juxtaposes parts of the system that have never been put together in this way before. I describe the presentation, and juxtaposition, more fully in the sections below. Before moving to that stage, there is one more element of this analytical process that is worthy of attention: participant validation and knowledge exchange.

PARTICIPANT VALIDATION AND KNOWLEDGE EXCHANGE

There was a disconnect in this project between my aspirations as the researcher and the reality of doing research in the field. I had high hopes that the individual participants would be invested in the research and share responsibility with me for its formation. I aspired to conduct ethnographic fieldwork and use observation to provide a nuanced and experientially-informed account of this field of practice. I had aimed for a co-produced research project in which the participants and I shared the construction of the knowledge and evidence shared in this (thesis) document. While participants supported me in my attempts to understand their day-to-day practice, a full-fledged period of observation of them in the field was too much to ask. Likewise reviewing transcripts takes time and all of these participants had highly demanding roles with little time to spare. In response, I sought opportunities to share this learning with them as a group.

To that end, I ran a three-part seminar series titled “Conversations in Health and Social Care” with my colleagues Ailsa Cook and Sarah Keyes at the University of Edinburgh (which I discuss further in Chapter 7). We developed three interactive, conversation-based, events on the topics of ‘collaboration and integration’, ‘trust and commissioning’ and ‘empowerment and care’ (Stocks-Rankin et al. 2013a). Each session included short presentations from practitioners and academics on the theme followed by discussion in multi-disciplinary, cross-sectoral, groups. I presented some of the work I from my thesis in the second session on trust, prompting a discussion about caring practices in commissioning and resistance work in care homes. It was the first time I had presented this material to some of the research participants. I was nervous that my analysis would not resonate — a feeling made worse by the high-turnout at the events. Speaking to a small group of participants was one thing, but speaking to 100 people including a range of commissioners from across Scotland was substantially more nerve-wracking. In the

conversations that followed, we talked about the importance of trust in the sector and the absence of relational, and emotional-ethical, language in our discussions of these practices. This feedback was a central development step for this work. It has validated my relational approach and the value of ‘talking about’ emotions. Moreover, the idea of care was familiar to these supposedly rational-technical bureaucrats as was the resistance and frustration I encountered amongst providers. This is something I explore further in Chapter 6.

I also took some of my early reflections to conferences and presented preliminary data analysis at the CRFR new researchers conference (Edinburgh, January 2011), the PG stream of the SPA conference (Lincoln, July 2011) and the Critical Care Conference (Brighton, September 2012). Writing these papers helped me to test some of my theoretical ideas against the data I had generated. The conference presentations in particular helped me to refine my understanding of the material I was working with.

PRESENTATION OF THE THESIS

The empirical data presented here reflects my efforts to begin with individuals and their work. It is deliberate in its efforts to resist the process of ‘nominalisation’ and ‘blob-ontology’ (Smith 2001, p166) — terms which Smith uses to convey the erosion of individual experience in favour of creating a synthesised whole. I talk about the work practices in terms which I think would be meaningful to the participants and recognisable as dimensions of our conversation which they shared and co-produced. This approach aligns with feminist scholarships and its interest in the production of research (Mendez & Wolf 2001; Jaggar & Bordo 1989; Bondi 2002; Haraway 1988). The value of feminist research lies in its efforts to look to local, everyday knowledge and to use this as “a ‘reality’ against which hypotheses are tested” (Harding, 1987, p7).

Throughout this following three chapters, I use Lather’s (Lather 1986; Lather 1995) method of ‘juxtaposition’ to provides insights from a variety of perspectives, and reflect different narratives around the NCHC. Lather’s approach attempts to provide faithful accounts of the participants experience and makes deliberate effort to separate these from one-another — and from the researcher’s own voice. In working with this concept of juxtaposition, I present the data in this thesis closely attached to the anonymised persona

of the person who I interviewed. Thus, I write about Steven from Stillwater Care or Craig from Oakleaf Care in order to give some sense of the rich, individualised detail, that was part of this interview. This means that I focus on the depth of individuals and draw out conclusions across perspectives at the end of sections and chapters. This is in keeping my narrative approach and focus on the 'stories' of stabilisation.

There are limits to the use of a juxtaposition approach — particularly in terms of the separation of my interpretation from the perspectives of the research participants. Arguably, the selection of quotations (and the 'cleaning up' process this entails) are part of an interpretive process. In absence of co-produced analysis and writing, I used a process of knowledge exchange to test some of the findings from this thesis within the sector. Nonetheless, an empathetic stance which attempts, at least, to grapple with the distinctions between me and the multiple individual perspectives I present here 'feels' better than amalgamating those perspectives into a pre-existing story in which they 'evidence' my argument.

ETHICAL CONSIDERATIONS

As is standard at the University of Edinburgh, I went through a process of ethical approval in order to undertake this research. In social science departments at Edinburgh University, there are three processes for attaining ethical approval which depend on certain risk factors in your research. "Level One" requires the student to undertake a "self-audit" that asks questions about the vulnerability of participants, handling and storage of data, and so on (Appendix 4). A "self-audit" is often all that is required for researchers doing work on policy and practice issues, particularly if people accessing support are not included in the research design. I completed a self-audit as part of my first year review panel (which determines my ability to progress and complete the PhD). The examiners agreed with my assessment of risk and I was not asked to undertake the second or third level of ethical review (which involve more detailed discussions about the ethical ramifications of the research and can require formal approval from an ethics committee). This ethical review process, as this the case with a number of institutional arrangements of this kind, does not deal with the specific ethical context of one's individual research project. It is a tick-box form that asks researchers to apply standard concerns about vulnerability (e.g. are you interviewing children) to ones research design.

As I have described above, I encountered a number of ethical dilemmas in my research journey — most notably the conflict I experienced with some interview participants which was representative of wider conflicts in the sector. The review process did not prompt me to reflect on how I might deal with conflict or whether there was likely to be tension in the research process. As I have reflected elsewhere (Stocks-Rankin 2014), there are important distinctions to be made between ‘ethical approval’ and ‘ethical research’.

To judge the ethical approach I took in this research, I refer back to my original research proposal and the ethical framework I sought to establish at that time. Given the inadequacies of the self-audit tool, perhaps the best way for me to account for my ethical approach is to compare the process with the aspirations of the novice researcher who described (at length) her hopes for this project. I quote from my panel review paper here and conclude with a discussion of the success (or lack thereof) of these principles in practice.

This research project is focused on the commissioning practices related to social care services for older people. As the bulk of this research will be carried out in Local Authority Social Service Departments, the traditional domain of social workers, this project has sought to ground itself in the Code of Ethics used by social work and social care researchers (Butler 2002). This Code is based on four key principles: autonomy, beneficence, non-maleficence and justice. These four principles will be adopted throughout the research project.

More specifically, the concept of autonomy reflects the researcher’s respect for the autonomy of others. As such, informed consent will be sought at the beginning of each new stage of observation and at the beginning of each interview. All participants will be informed of their right to decline to participate at the beginning of the data collection process. This right will be reiterated at key stages throughout the observation and interviews. The confidentiality of participants will also be maintained throughout the data collection, analysis and dissemination of this research.

Moreover, the researcher will endeavour to be open and honest about the research project with each participant in so far as that openness does not compromise the autonomy of others. In this way, the project aims to provide a constructive space for dialogue. It is hoped that a genuine effort to create dialogue will facilitate a more participatory research project. Ideally, participation will help to minimise the risk associated with consent by ensuring that all informants are fully conscious of their

right to control their level of involvement.

The project will make every effort to prevent harm. Given the current policy focus on fiscal restraint, commissioning for services is likely to be a particularly contentious area of practice within the Local Authority. It will be important throughout this project to ensure that participants feel confident that the research process and outcomes will maintain their confidentiality. The use of 'respondent validation' should ensure that the interpretation of the data accurately reflects their own views. Moreover, 'respondent validation' will provide an opportunity for individuals to add to the existing interpretation. In this way, participants may feel they have more control over the research output. It is hoped that these measures will ensure that harm is minimized throughout the project.

Where possible, this project will strive to empower participants through open dialogue and participation. This is in keeping with the values of social work which seeks to empower and provide opportunities for transformative or emancipatory change (Butler 2002). Importantly, change of this nature will be identified and carried out by the participants. The researcher's values or opinions in this matter will be minimised.

This project seek will seek justice through the openness of the project to respondent validation. It will endeavour to represent the perspectives of the participants fairly and will give individuals the opportunity to comment on the data and analysis produced. Importantly, the research aims of the project or the researcher will not eclipse those of the participants.

(Stocks-Rankin, Panel Paper, November 26, 2010)

In reflecting on these aspirations, I think this project as been largely successful in its efforts to approach the generation, validation and presentation of data in an ethical way. Based on my own principles for this research (as outlined in 2010), I did validate the data with those participants who were interested (though of course realised that not everyone was in fact interested). I did work hard to ensure that participant autonomy was respected and that my own "opinions and values were minimised" — aligning myself instead to the interviewee's perspective and including those different perspectives in the formulation of the empirical chapters in this thesis. I have followed the guidelines of these ethical protocols and anonymised all data included in this thesis. I was open about my research, asking permission to record and use the data. I have 38 signed consent forms in my files. Where requested, I sent participants summaries of the interview and/or audio recordings in addition to transcripts.

But, my experience of research also leads to me to make some comments about current conceptions of ethics in policy studies (and social science research more broadly). First, our definition of 'harm' is under-developed in policy research. Although I was conducting 'elite' interviews with commissioners, contract managers, care home managers, social workers and inspectors, there are vulnerabilities here. The idea that vulnerability is attached to a 'category' of person is far too simplistic. As Katherine Smith notes, "researchers ought to reflect more carefully on assumptions about where power lies and should consider that the power relations social scientists sometimes employ in relation to society at large do not necessarily translate directly into the interview space" (K. E. Smith 2006, pp.651-2).

Second, I continue to feel a sense of responsibility to the participants in this project. As I note above, I have only used 1/3 of the data I generated for this project. I feel an ethical duty to make use of the remaining data and will do so in future publications and research in the sector. Too often however, it seems that researchers are focused on the production of their 'project'. By not including those voices — as confident as I am that it is the right decision to make given the requirements I need to meet to produce a pass-able PhD thesis — I am also clear that I have not yet lived up to the ethical duty that data requires. It's far too simple to say that the excluded data 'informs' the thesis. Of course that's the case, but those voices and their narratives are not yet able to be heard and I have a responsibility to make use of them going forward.

Finally, as I note above, conflict was a significant part of this research process. As researchers, we may need mechanisms to support the management of that conflict. PhD supervision may be one way to deal with this — though that was not a fruitful avenue in my case. I relied on the insights of other feminist colleagues interested in power and familiar with the conflict that that interest can create to find strategies for dealing with these challenging parts of this research process. The reflective practice and the honest writing of other critical researchers have also been invaluable to this process.

To conclude, I am confident in my claim that this research has been ethical — both in terms of its formal approval from the University of Edinburgh and my own efforts to negotiate the ethical dilemmas I encountered. I have gone on to use the conflict I

experienced in the field to theory-build and have produced a more robust, and innovative, analysis as a result. But, more conversation is needed amongst social scientists to account for the practical, lived, ethics of research.

CONCLUSIONS

Much of my research practice was an intuitive and reflective process. I brought a set of interests and skills which were honed elsewhere. Everyday work and emotions are the bread and butter of my everyday life — doing research on an area which is akin to my own social care practice helped me to ‘see again, differently’— but the focus on work, on the micro-processes which make up an organisation and system — is the same. More unexpected is the relevance of emotions for this research. This thesis weaves together the experiential accounts of everyday knowledge practices contract manager or a commissioner of care services for older people. It also maps the significant relationships in the care system and give accounts of the translation work that is carried out to stabilise those relationships which make up the care system. These accounts are illuminated by the emotional dimensions of the interview conversation. While the stories and maps provide a structure, a set of discernable ‘facts’ in the conversation, the emotional layers paint the picture and give substance and depth to these stories.

Following in the tradition of Institutional Ethnography, this thesis aims to give an account of ‘how things work’ (Smith 1988, p.147) in the world of contracting and managing care homes in Scotland. In telling these stories, I have drawn on the work of IE and practice-based theories of knowledge (Yanow 2004) to help me give an account of the knowledge practices at work. I have looked to ANT (Callon 1986; Law & Singleton 2005; Dugdale 1999; Star 2007) to understand the stabilisation work that participants seem to be undertaking to make the care system function. And I have looked to the literature on emotions and ethics (Hochschild 1979; Holland 2007; Sevenhuijsen 1998; Mol et al. 2010), to provide a relational ontology with which to explore the interdependency I encountered.

I also draw from ANT to investigate the horizontal process of stabilisation and its reach across networks. This effort at stabilisation might be thought of as the activities involved in bringing entities into a durable relation with one another (Law 1999; Freeman 2009). This project investigates the activities that actors undertake in their day-to-day making and remaking of the care homes system — and the tools they use to do it: the NCHC text.

The NCHC document formalises a set of relationships through the written text, its incumbent terms and conditions, and required monitoring and review. The empirical material which I grapple with in this thesis stretches Callon's (1986) four moments of translation vertically — and IE's conceptualisation of ruling relations horizontally. The analysis pulls from the 'micro-processes' offered by Callon to focus on the mechanisms which combine to stabilise. Inspired by IE's explicit efforts to grapple with conceptions of power, and using language which works to include people rather than abstractions, I draw attention to the 'stabilising work' of people in the care homes sector.

In this project, I began with two approaches, ANT and IE, which I see as complementary, each offering something which the other was lacking. ANT offers IE a robust set of mechanisms with which to unpick the micro-processes of stabilisation. Callon's (1986) paper, expounding the phases of problematization, interessement, enrollment and mobilisation, is just one of the many examples of the rich theoretical concepts that ANT can bring. This reification process is a powerful one and IE is more adept at exploring the relations of power and domination that occur in systems of activity. In drawing together these two approaches, I have sought to give a more ecological account of stabilisation and the operations of the actors that seek to produce it. Instead of the flat account of enrolment which overrides resistant narratives and knowledges, in this thesis I focus explicitly on the gulfs of difference between actors and their experiences. This is not just a story of stabilisation, this is a story of de-stabilisation. It is an account of the paradox of processes and the potentially productive tension between them.

4. CREATING THE NCHC DOCUMENT

INTRODUCTION

There are contrasting stories about the origin of the National Care Homes Contract (NCHC) and its role in the sector. The unifying feature of these stories is the stabilising work that the document does, whether for care homes, local authorities and, more obliquely, for people who access support. In this chapter, I present some of these stories and show three dimensions of the production of the NCHC text: the different drivers for creating a national framework agreement, the work which went into its production, and an account of the artefact itself.

The production of the NCHC that I depict here focuses on the making and re-making of the document at the national level as well as the artefact of that production: the NCHC text. It is a partial account of the document's production based on a core group of interview participants who had direct experience with the writing and use of the first contract document.

I look first to the production NCHC document. I was fortunate in being able to speak to some of the people involved in writing the first version of the NCHC text in 2007. I present the perspectives of two participants, Harry and Mark, who helped to write the first NCHC text. I also present material from my interview with Alexander, an early adopter of the NCHC text from the care home sector. Drawing on their accounts, I focus on the need for stabilisation in the sector and the mechanisms that were included in the contract to meet that need.

This section is followed by an analysis of the document itself in which I focus on the mechanisms of stabilisation as they appear in the 2010 contract document, which was the current version at the time of this research. Three interlinked mechanisms are investigated: the categorisation of care, the development of a fixed price for all care home services in Scotland, and the use of incentives and penalties to promote the quality of care.

In the third section, I look again at the drivers for the NCHC document and direct my attention to the practice needs in the sector. In this section, I tell the story of the “impossible work” of contract management and the “chance” for support which arose with the NCHC in 2007.

Through these three accounts, I emphasise that the NCHC is the product of negotiation. The NCHC reflects the needs of two otherwise opposing actors in the sector: care homes and local governments. Its existence is a product of their on-going collaborative work to stabilise the sector. As a boundary object, it sits between the boundaries of their practice and binds them into a relationship with one another. By definition, boundary objects are “simultaneously concrete and abstract, specific and general, conventionalised and customised. They are often internally heterogeneous” (Star & Griesemer 1989, p.408). Their flexibility enables them to bridge the world of local government planning/ monitoring and the very different practice of service delivery. But, as Star and Griesemer note, there are “boundary tensions” (Star & Griesemer 1989, p.410) between these fields of practice which then need to be negotiated and resolved. In this chapter, I explore those tensions as they play out in the formulation of the first NCHC boundary object.

OVERVIEW OF THE NCHC TEXT

The NCHC was first written in 2007. In practice, the NCHC operates in two forms: a national framework agreement and a local authority contract for services. As a national framework agreement, it applies to all 32 local authorities in Scotland and each of the independent and charitable sector care homes that choose to accept publicly-funded residents. In this form, the NCHC is an umbrella policy document for care homes services. Its primary accomplishment is its definition of a national price for care home services as well as standardised terms and conditions for the service. This means that each of the 32 local authorities in Scotland and a majority of independent and charitable sector care homes agree to, first, a fixed fee for the care they provide and, second, universally defined responsibilities.

The 2010/11 NCHC text is divided into three sections: definitions, service specification, and finance. It also contains a section of appendices including: the individual placement agreement for new residents to a care home, details on the free personal and nursing care

policy, a declaration of the care home's financial viability, and a list of the nominated officers. In total it is about 50 pages long. It uses standard legal phrasing (e.g. the third person, abstract language) throughout to delineate the responsibilities of the care home, local authority and resident. For example, the contract states that "the Provider shall provide to the Resident the Standard Care and any Additional Care in accordance with the Care Standards and any requirements made by the Care Commission (now known as the Care Inspectorate)" (NCHC 2010). A complex phrase meaning that the care home will provide care and support to the person who chooses to live there.

The NCHC document is the result of negotiations between national representative groups: COSLA on behalf of Scottish local authorities, Scottish Care on behalf of the independent sector, and CCPS on behalf of the charitable sector. Once the NCHC is agreed at a national level, individual local authorities use this document as a template to create a contract with each care home in their local area. Small variations can be included at this time, though my conversations with contract managers suggest there is not much deviation from the original text. The key focus of these national negotiations — price — must remain fixed.

TEXT WORK: DRIVERS FOR FRAME AND ASSEMBLAGE OF THE NCHC

In this chapter, I suggest that there are contrasting stories about the origin of the National Care Homes Contract. In drawing attention to these different perspectives, I highlight the key drivers for stabilisation. These accounts are based on the conversations I had with a small set of interviewees who were involved in writing the first NCHC text (Harry and Mark and Alexander).

Harry and Mark were both employed by local councils in 2007 when the suggestion of the NCHC was first proposed. Harry and Mark were recruited to be part of a small advisory team that drafted the first NCHC document. This group was composed of local authority staff familiar with contracts and services for older people. In their accounts, they describe receiving support from COSLA and some additional legal advice to prepare the contract text. I also conducted an interview with a member of the independent sector lobby group, Scottish Care, who was a user of the first draft of the contract (Alexander). Alexander is a member of the independent sector lobby group, Scottish Care, who was a user of the first draft of the contract and a central part of the on-going re-negotiation team. Interview data

from Alexander adds important nuance from the 'other side' of the contract relationship, shoring up some of the perspectives from Harry and Mark and offering important distinctions, particularly in terms of the drivers for an NCHC document.

The following section provides a history of this text's production. It focuses on two aspects of that production. First, it describes the drive to create a national framework agreement. Second, it accounts for the rationale behind the content of that national agreement. I present these processes as two distinct phases: frame and assembly. These terms help me conceive of the two related kinds of work which went into creating the NCHC document: the decision to create a contract and the labour of deciding what exactly that contract should include. Both kinds of work reflect the need to stabilise relationships and patterns of activity in the care homes sector. Texts, as Smith suggests, "are key devices in hooking people's activities in particular local settings and at particular times into the transcending organisation of the ruling relations, including what sociology calls institutions and organisations" (Smith 2001, pp.164-5). For the creators of the NCHC text, this 'hooking in' was a central motivation for the creation of the document. Care homes and local governments had widely different approaches to the planning and delivery of care homes for older people. As this thesis will go on to show, the interdependence of their activities required them to formulate a more coherent approach to care services.

FRAME

This account provides insight into the rationale for creating a national contract document from some of the people who were involved in its creation. It gives an account of their views on the policy context and the drivers to create a national framework agreement. As early designers and users of the contract, Harry, Mark and Alexander highlighted specific dimensions of the policy and practice context that prompted the development of a national contract agreement.

For Mark, the "increasing cost of care" was one of the largest concerns for the sector in 2007. He links the cost drivers which underpinned the Community Care reforms of the 1990s to the issues facing planners in the late 2000s. When I asked him about the current state of care homes services in Scotland (where we have been and where we are going?)

Mark talked first about the 1990 NHS Community Care Act and the “hidden” rationale behind the reform.

Mark: One of the big things that the [1990 NHS Community Care Act] did — that legislation was designed to deliver community care —but one of the key factors behind it was the increasing cost of care. And one of the key factors was to get that cost away from, uh, was to manage that cost. If GPs put people into care homes and central government picked up the tab, there was no, monitoring system in there, so one of the things that [the legislation] did was that the funding went from HSS [the health budget] to local authorities. And the decision to place someone in a care home became a local authority decision. That was part of the rationale behind the thing because if you were seen by a GP for a service that they didn't pay for there was no accountability in that.

Mark highlights the significance of the cost drivers and goes on to emphasise that the ambiguous responsibilities of health and social care sectors created a “lack of accountability”. Without the accountability for the financial costs of the care provided, the costs of care were thought to have spiralled out of control. Mark articulates that there was a need to “manage” the costs and “get them away” from the loose hand of the health sector, particularly GPs. For Mark, it seems that costs were a “hidden” driver for the NHS Community Care Act 1990.

Mark: So that's the sort of, it's not an upfront reason, it's more of a hidden reason behind the implementation of community care, but that was part of the rationale behind it. It's a political reason that obviously wasn't brought to the surface.

His revelation of this to me in the context of our discussion of care homes was punctuated with statements like “did you know this?” In part, this reflects Mark's position as an expert on social care policy in Scotland, compared to my position as a novice in this area — I think it also reflects his sense that this was a history that he felt needed to be told. As I suggested in Chapter 2, the ‘Community Care Reforms’ in the 1990s made local governments responsible for the financing and organisation of care services. The shift was one of the central recommendations of the Griffiths report (the white paper which was the precursor to the NHS Community Care Act 1990). Sir Roy Griffiths raised concerns about the ‘loophole’ in the social security budget, suggesting that these costs were spiralling out of control. The NHS Community Care Act 1990 closed the loophole, thus reducing the ‘burden’ on the social security budget and shifting the responsibility for financing to local governments. This was coupled with a new responsibility for reviewing care needs and

monitoring care placements. Accountability was a key driver for the shifts that Griffiths recommended, but Mark suggests that the primary impetus was financial. From that point forward, the rising costs of care became a concern of local government and they continue to underpin the policy discussions to this day (see COSLA et al. 2011).

For Harry, the financial pressures are framed in terms of the needs of the independent care home sector. In Harry's account, the independent sector providers "coalesced" around concerns for the financial viability of the care they were providing. These consolidated positions grew into a representative lobby group called Scottish Care which works to secure a voice for the independent sector and argue a case for the increased fee payments for care home placements.

Harry: Basically what had partly happened is that the providers started to get organised ... they were saying we're not getting enough money for the care we're providing and they threatened local authorities to just basically go on strike and refuse to take any more places. So there's a whole lot of publicity about that and then they coalesced into an organisation called Scottish Care which became a representative organisation.

Harry's account suggests the driver for a national contract was the motivations and activities of the independent care sector. He suggests that their fears for the financial viability underpinned their desire to organise and drive forward the idea of a national framework agreement.

Harry: So it's partly that the providers became increasingly well organised and Scottish Care was used to lobby, make a lot of noise, publicly, and I don't know what happened but they got the ear of government at the time. What came out of it then was there'd been some discussion between government, COSLA and Scottish Care, and they basically put a deal on the table: we will offer more money in return for a contract.

From Harry's perspective, the driving forces behind the creation of this contract were the financial pressures on care homes and the 'politics' of the care sector. The development of a national contract was not driven by the strategic planning and policy development in local councils. He is clear that the contract was driven by the 'political' realities surrounding care home service delivery: "What's clear is that it didn't come as a result of strategic commissioning, right, it came as a result of politics okay". Harry's account of the political backdrop highlights the financial pressures that were prominent in the policy

space. Importantly, it also highlights the partnership working which surrounds the development of a NCHC text. The private sector formed a representative group to take forward its needs with Scottish Government and representatives of local government.

The concerns about costs and the transparency in the care home sector were identified in a series of reports of care homes by the Office of Fair Trading (OFT) (Office of Fair Trading 2003; Office of Fair Trading 2004b; Office of Fair Trading 2005). At that time, the OFT's chairman, John Vickers, said "Serious questions have been raised about the adequacy of price information for potential care home residents and their representatives. Our study will make a thorough assessment of this and other factors which may have a bearing on competition and consumer choice in this market" (Office of Fair Trading 2004a).

Harry described the influence of the OFT reports on the sector.

Harry: But there was also there also was the Office of Fair Trading which had done a report into care home fees and had found unfair terms and conditions so there was that policy driver for this too — so there wasn't just the politics. I suspect people saw the OFT, saw that there was the financial stuff. So there were a few things and it all came together in terms of "yeah contracts is a good way out".

Harry suggests that the OFT report was a driver for the NCHC. He also stresses that the influence of the financial pressures and political pressures to reform (and regulate) the care home sector were primary drivers for the creation of the NCHC. The implications of this for the care home sector were outlined in the guidance from the OFT which suggested that all providers should have a transparent pricing system and a clear price mechanism for the care provided, i.e. price for care should not change depending on wealth or other factors. Mark highlighted this requirement in his description of the changes that were required of the sector.

Mark: There were other factors – one was that there was a requirement for the care home owners to print one brochure with one pricing system. Only one brochure, and only one pricing system which was open and transparent to all.

This drive towards transparency and a single price was taken up by this group in the creation of the NCHC text. But, they went one step further than the OFT's guidance

suggests.. They developed a single pricing system for all care homes in Scotland. This agreement is one of the primary stabilisers in the NCHC document.

Not all parties are in agreement about the driver for that stabilising device. Inconsistency in price and a shifting of responsibility are key drivers for local governments' desire to create a national framework agreement. For care home managers, the central driver was a lack of financial stability. For Alexander, the care home sector was in crisis at the time the national care homes contract was created ± without it they "couldn't continue" to provide care.

Alexander: When it [the National Care Homes Contract] was introduced, they'd [the care home sector] got additional investment. There was a crisis at the time in terms of really care homes saying we can't continue, unless there is a step change in the funding of care, and the national contract was seen as a vehicle for that.

Harry frames the debate in terms of the activities of the care home providers: "they threatened local authorities to just basically go on strike and refuse to take any more places". Harry looks towards the care home sector — its lobbying and threats — as an impetus for the development of the NCHC. In contrast, Alexander looks towards the structural limits of government financing for care for older people. These narratives reflect the lingering impact of the community care reforms, which placed the responsibility for financing and organising care home services firmly within the local government's domain. They also reflect the continuing significance of the financial pressures, both as drivers for the community care reforms and the NCHC itself.

The theme of cost echoes throughout this stream of narratives. In an effort to reduce the cost of the care home placements and the burden of expenditure on the Department of Social Security — care home financing was made the responsibility of local government. However, the costs themselves remain. Their relocation from one budget to another does little to stem the reality of the cost of care. The accounts of Harry and Alexander echo this reality.

Faced with local government budget constraints, the care sector "coalesced" and creates a lobby group to represent their collective interests. According to Harry, a deal was struck and more money was set aside for care homes in return for stable terms and conditions.

More financial investment is the trade-off for increased transparency around service provision and clarity on the cost/price of care in the sector. From this perspective, the contract provides standardisation, a national framework against which all local authorities can arrange their care home services.

ASSEMBLY

As the previous section shows, the context was unstable. The drive to stabilise the sector through a contract document was underpinned by “political” decisions to shift care homes into local government responsibility, a “crisis” in funding for care and high profile reports on the need for transparency and higher quality of care for older people. The following section investigates some of the specific decisions about the contract’s content. Its designers extended their concerns for stability and increased levels of financing through the inclusion of quality measures, consistency in terms and conditions and a standardised price index.

For Harry and Mark, as representatives of local government, the content for the NCHC was informed by their experiences with contracting for care home services. From their perspectives, there were inconsistencies in the price of care home placements across Scotland and even within individual care homes. In Mark’s description of the sector, he suggests that care homes had a tendency to charge ‘top-up fees’ — an additional price for services that meant that service users were required to pay out of their own pocket above the local authority sponsored payment for their care home place. In other cases, Mark suggests that individuals with perceived higher incomes were charged more for their place in a care home. For Mark, these inconsistencies had become a problem for local governments and the NCHC was a potential solution.

Mark: We recognised after a number of years that the fees that people were paying in care homes were different, so that you made an appointment to see a care home owner about potentially placing your mother or father in a care home, and the care home owner, watched the kind of car you drove up in, and if you drove up in an expensive car then he would charge a higher price. If you drove up in an old banger then you were charged a lower price and there was no transparency. Secondly, there were things called top-up fees. It was entirely unclear about what the top-ups were for, who was paying them and why some people paid them and others didn’t. So we then get involved in the negotiations for a national contract with Scottish Care and the intention of that was to have

one national contract, and one national rate across the board so that the local authorities were paying a single rate for care.

Concerns over quality of care were also incorporated into the contract. The driver for this is less clear, though both Harry and Mark comment on the importance of tying the price of care home services to a quality indicator.

Harry: Someone then had the idea — and it was a very good idea — to make payment dependent on the achievement of quality measures. We needed to do something that was quick and was workable that was going to achieve something. It wasn't very sophisticated – but actually you needed something you could measure so we ended up doing some stuff around training for the contract.

There is an emphasis on the practicality of this approach. Harry discusses the need to create measurements for staffing levels as a proxy for quality and use these proxy measures as an incentive for care homes. Harry suggests that the mechanism they selected was “workable” — it was something they could bring into being. Though it wasn't “sophisticated” it was designed to bring some measure of the quality of care into their relationship with care homes.

Harry elaborates on the construction of this measure, a mechanism which was based on levels of certified training: Scottish Vocational Qualifications (SVQs). Harry acknowledges that staffing levels are a proxy measure and points out the developmental process which surrounded their effort to track quality of care. Since the first NCHC document, the efforts to measure quality have progressed and now the payment mechanism is tied to the Care Inspectorate's grades (NB: the “quality award” is an incentive for high staffing levels (now called Care Commission grades)).

Harry: Two or three of us knew that the SSSC [Scottish Social Services Council] were pushing some training levels and we thought, well actually if we can't measure quality itself at least we could look about whether they're putting staff ready for it. The quality awards started focusing on that, but gradually as the Care Commission [now known as the Care Inspectorate] became more established, the focus has been linked to Care Commission grades. So there's a been a whole sort of development process about that.

Harry suggests that his work on the first NCHC contract draws upon the SSSC's advocacy for SVQs. His reflections suggest the contingent and developmental nature of the contract's production. This draft was reliant on the experience of the people who were

recruited to write it. In turn, their knowledge was contingent on the work of others in the sector. As the Care Commission developed, the grading system became more coherent and the proxy measure for quality shifted from staffing levels to Care Commission grades. As Harry goes on to note, these negotiations also ensure that the council's responsibilities were more clear.

Harry: Local authority contracts tend to be quite one sided which we always thought was not fair, so we did a whole lot to make clearer the responsibilities and response times of the Council — managing all of that stuff went through the negotiation process.

Likewise, Mark's account underscores the work that was involved in developing this proxy measure. Like other aspects of the contract document, the development of proxy measures was negotiated with Scottish Care. Penalty measures were introduced alongside the "quality award" described above to provide an incentive for the improvement of quality.

Mark: There was a quality element associated with this as well. Now we struggled long and hard to work out what the quality indicators should be, and in the end decided on proxy indicators which was the numbers of staff that were trained to SVQ 2 level. That was part of the negotiations with Scottish Care and that meant that a percentage of staff had to be qualified to SVQ. That was something which each council was going to monitor on an annual basis, and if [care homes] didn't meet that standard then they got the penalty.

As Mark notes, the staffing standards were monitored by the council and tied to the weekly payment for local authority funded care home residents. Deviations from the guidelines proposed in the NCHC document were met with a reduction of the payment (a penalty).

This national framework agreement/contract provides standardisation for quality of care across all care homes — first by linking quality to staffing levels and then to the quality grades from the Care Inspectorate. The creation of a penalty/incentive system in the pricing of care home placements indicates a desire for long-term service development. This is underscored by Harry's account of the development of Care Inspectorate grades as quality measures. The accounts of Harry, Mark and Alexander each reflect a desire to

improve care home services. The contract is one of the devices they use to do that improvement work.

But improvement is just one part of this story. There is a clear focus on price/cost throughout the assembly negotiations. Inconsistencies in price and the use of top-up fees are 'solved' with the use of a standardised price across each local authority and private sector care home. This is useful for care homes so that they can plan their businesses effectively by ensuring that they know year on year how much money they will receive for publicly-funded residents. This standardisation also helps local authorities to ensure that there is some limit on the fees that care homes can charge. This is particularly important in affluent communities where the care market can support higher prices for services provided.

Harry outlines the people and organisations involved in the first draft of the NCHC document. For Harry the process of negotiation is significant. Scottish Care and COSLA, representative bodies of the care sector and local governments, brokered the content of the first NCHC document. Harry's involvement becomes clear through this passage. Both were recruited, along with two or three others from local government, to draft the document based on their own experience with contracting.

Harry: [The production of the contract] took place under the COSLA umbrella, but because the COSLA people didn't know about contracts, [they needed] the four or five people across the country who had been looking at contracts. We were on the negotiation team right and COSLA sat behind us and we argued every point and out of that came a contract. COSLA then through their structures consulted with councils and the Scottish Care consulted with their members, and councils also sent it out to all providers in their area so there was other consultation, then we then came together with the first version of the National Care Homes Contract and it was, in fact, it was a negotiation process which also was negotiated from a Scottish perspective.

Harry's account shows the process of consultation which accompanied this draft. Both COSLA and Scottish Care sent drafts of their contract to their members for review. Given that Scottish Care was a new organisation with a small official membership, the councils also sent the contract to the providers in their area. This consultative process that Harry describes gives some indication of the deliberative nature of this assembly process. Representatives from local government and Scottish Care debated the terms of the

contract, but they also ensured that their “members” had an opportunity to comment on the document. Harry goes on to suggest that this was negotiated from a “Scottish perspective”. The ‘Scottishness’ of the document is significant. All 32 local governments now have a standard price for care home services, regardless of market conditions. This means that there are no price variations in the country — it keeps the “lid on” on the price and prevents providers from increasing their prices in wealthy areas or reducing their expenditure/quality in low-income areas. This theme of stability comes up again in the following two chapters in which contract managers and care home managers describe the value of the standard process of having one contract for all care homes in their area.

A STEP FORWARD: REVIEWING THE VALUE OF THE NCHC

When asked whether the NCHC was a good thing, Alexander, Mark and Harry each articulated a largely positive account of the contract document. Each promoted the idea of national negotiations and the communicative work that the document requires as a central benefit of the NCHC.

For example, in highlighting the problems which the NCHC sought to solve (e.g. inconsistencies in the price of care home places), Mark suggests that the creation of the NCHC “set the precedent” for national negotiations and has created a national conversation about the direction of care services.

Mark: The issue about community care, the community care legislation from 1990, was that it introduced the concept of choice, so you could choose which care home you went to — the problem was if some care homes charged more than others, then, you could only go to those care homes as long as the top-up fee was paid. So, it stopped all of that, and it meant that people had more choice and could decide where they wanted to go. The system was quite transparent. I think it was beneficial from that point of view, very much so, and it also set the precedent and created the environment where you could have national negotiations. That was a key part of it.

Harry is also clear that he felt the NCHC has been a positive direction for the organisation of care home services. Specifically, he highlights the work and “resources” which are required in a system where local authorities negotiate separate contracts for care home services.

Harry: Well I think the whole thing has been a good thing and it still is a good thing and I think it's very much the right way to go although there are weaknesses there. I mean [in] my experience most councils had not been able to get in place their own contracts. One of the difficulties of doing that is that if you're consulting on something is everyone's consulting separately and everyone's gotta get a dedicated expert team. If you're trying to test it with providers there's huge resource problems, so what you find is that contracts teams have always got an enormous backlog of work to do there's far too much work to do. Actually where the National Care Homes Contract was a step forward is it well here's one area where it makes sense for everyone to work together right.

Alexander, who is the most measured in his comments, suggests that even though there are deficiencies in the contract the review process offers opportunities to progress the current framework.

Alexander: I think it's delivered certain things. It has certain deficiencies, but I think there is probably at the moment, universally, there is a reluctance to let go of it until we've got something better to put in its place. [Something] that might allow more localisation for instance as one of these two categories of care, residential and nursing are in themselves restrictive and not very reflective of the range of needs that currently apply. So there's hopefully further progress to be made on the contracting framework.

In summary, the NCHC document created clarity in the sector by establishing a set of terms and conditions for the care provided. Importantly for each party, it set the fee rate for all residents receiving public sector financing for their care. Concerns over quality prompted the framers to include staffing measures as a proxy for quality of care. These were linked to an incentive/penalty system and care homes with high levels of quality received financial rewards and underperforming care homes were penalised.

These drivers reflect a set of "information needs" (Star 2010, p.602). Local authorities needed more information about the care that was being provided. Care homes needed more information about the payment they would receive for that care. Some of these information needs were addressed through the formalisation of responsibility in the contract and the creation of a clear pricing system. But beneath these drivers is a more urgent need. The relationship between care homes and local government required stabilisation. Local governments wanted to know more about the care homes services in their area and have some clarity on the price they would be charged for publicly-funded residents. Care homes were threatening strike action and local authorities were still

reeling from a change in their responsibilities under the Community Care legislation as well as the findings from the OFT report which suggested that care homes were chronically underperforming.

The aim of producing the NCHC text, as I understand it, was to standardise the information about the care home system and stabilise the exchange between local governments and care homes. At the core of these drivers is the need for stable relationship. This was manifest in the need for transparency and some measure of technical stability in price and quality measures. Between them, local government and the private sector care homes are responsible for all of the residential care for older people in Scotland. In their negotiations about the framing and assembly of this NCHC document, these two groups achieved a functional level of cooperation (if not perfect consensus) to produce the national framework/contract document. This agreement is one moment of stabilisation in that the NCHC text accomplishes.

THE NCHC TEXT: RELATIONS BETWEEN PRICE, QUALITY AND CATEGORISATION OF CARE

The result of the negotiation between local governments and care homes is a contract document — not a briefing paper or guidance as would be common in other areas of policy. This document is a binding legal framework for the responsibilities and activities of care homes, local governments and — at least in part — people accessing support. The NCHC lists a range of expectations. For example: the timely payment of fees, the burden of financial responsibility for equipment and toiletries, the management of a resident's belongings after death. In delineating and describing these different responsibilities, the document formalises a set of practices for the delivery (and receipt) of care, as well as the practice of managing the contract itself and the relationship between local governments and care homes during the life of the contract. The formalisation of these practices is based on a set of shared meanings about the nature of care that will be provided, its cost and the need to ensure that it meets established standards for safety and quality. It is these shared meanings that I explore here.

CARE: DEFINED AND CATERGORISED

The 2010-11 contract opens with the section: “definitions, interpretations and related matters”. The purpose of this section is to both identify and define the boundaries of shared knowledge. The terms listed in this section delineate the keystone concepts in the planning and delivery of care home services. By naming and giving meaning to these concepts, the contract creates boundaries around what can be known and how it can be defined. The terms in the first section of the contract, “Definitions, Interpretations and Related Matters” are technical and their technicality is situated in local policy meanings.

Care is defined in the following way within the contract: “‘Care’ means Standard Care and any Additional Care that the Council has assessed the Resident as requiring” (NCHC 2010, p.5). The meaning of care as a hierarchical set of activities is codified within this text. Care is defined in terms of ‘standard’ and ‘additional’ care. The definitions support each other. Standard care can only be understood with reference to the concept of additional care and vice versa. These concepts create a binary meaning for care. The nuance of care as a value and practice is reduced to two categories in the NCHC document. The complexity of care — the messy work of providing care — is neatly excluded. These two levels, standard and additional, are also assigned a definition. ‘Standard Care’ is defined as “the accommodation, provisions, personal care, support and/or nursing services specified within the service specification” (NCHC 2010, p.8). ‘Additional Care’ is defined as “any personal care, support or nursing services identified in the Resident’s Care Assessment that would entail the use of more staff hours than the Provider would normally need to use if that Resident was assessed as requiring only Standard Care” (NCHC 2010, p.4). The idea of ‘additional care’ incorporates an implicit understanding of ‘standard care’. The meaning of additional care is based on the measurement of staff hours that are used to provide ‘standard care’. If more hours are used, than this kind of care is termed ‘additional care’. While the measurements of standard and additional read like objective and fixed measurements they are actually situated, and dependent, on an individual resident’s Care Assessment.

Stabilisation of meaning occurs through a knitted network of terms. Referencing and cross-referencing terms deepens their significance in the field. The comparison of

standard care and additional care — where the meaning of one term delineates the possibilities for the meaning of the second term — embeds these concepts within one another. The meaning of ‘standard care’ is changed as a result of its link with the idea of “additional care” and vice versa. In the absence of additional care, standard care is just care, and the hierarchy of care within the contract framework would be absent.

Similarly, the concept of ‘care’ is only meaningful in relation to the tasks as outlined in the Service Specification, a section of the contract which is seven pages and 14 clauses long. The ‘Service Specification’ includes clauses about the resident’s clothing and laundry, including the requirements for bed linen, labelling of clothing, and damage to personal effects. Additional clauses detail meals and snacks, personal and health care including reference to the Care Plan, a prohibition on the use of restraints, and the on-going assessment of health and care needs. Care in the NCHC is task-oriented — pinned down to observable and quantifiable activities. Without the service specification to define its boundaries, ‘care’ would be a much more flexible, interpretive, concept.

These processes of categorisation suggest that the complexity of care can be trimmed to fit these boundaries. Care, as defined with the NCHC, suggests a hierarchical categorisation of normal and abnormal — it is either ‘standard’ or ‘additional’. This hierarchy is entrenched in a cost mechanism which further embeds a sense of hierarchy, i.e. ‘additional’ care costs more than ‘standard’ care. The concept of ‘care’ is also nested within a web of other definitions. ‘Standard Care’ is dependent on an understanding of the entire service specification. Moreover this concept of ‘care’ is systematically linked to other stabilising devices, notably a price mechanism and an incentive/penalty system — both of which I go on to discuss now.

THE ‘PRICE’ OF CARE

The categories of care — standard and additional — are further stabilised through their link to a price mechanism. Standard care with nursing costs £580.11 per week (NCHC 2010). Standard Care without nursing costs £499.38 (NCHC 2010). The cost of additional care is not specified. Additional care charges are negotiated on an individual basis through the placement agreement that the person accessing support establishes with the care home. These terms create the notion that care can be confined and defined in

bifurcated ideas of standard and additional, nursing or personal care. It further entrenches a hierarchy of these terms. Additional care costs more than standard care. Nursing care costs more than personal care. The addition of a price brings new meaning, and weight, to the definition of care.

Establishing a national fee rate which applies to all publicly-funded care home residents is the defining feature of the NCHC's role as a national framework agreement. The next chapter explores some of the reasons why contract managers find the standardisation of price useful. Use of the NCHC is thought to reduce the conflict in the sector. Agreement has already been reached by the time the finalised NCHC lands on a contract manager's desk. This makes their work with the local authority that much smoother – there is no need to tender and procure services, and there is no need to argue about price. As the following section will show, the negotiations around price are one of the most contested and more important elements of the NCHC's re-production.

PENALTIES AND INCENTIVES

The NCHC includes a financial penalty and reward mechanism. Care homes are regulated by the Care Inspectorate, which evaluates quality and gives an annual grade to the care home indicating its level of performance. Grades range from one (low quality) to six (high quality) and cover a range of indicators: quality of care and support, quality of environment, quality of staffing and quality of management and leadership.

The financial reward/deduction clauses of the NCHC are tied to these grades. High grades (5 and 6) will elicit an "enhanced quality award" ranging between £1.50 and £3.00 per resident per week. Low grades (1 and 2) will reduce the weekly fee rate by 7.38% for nursing placements and 8.58% for residential placements (see Glasgow City Council 2010).

The penalty and incentive system within the NCHC links care to the Care Inspectorate and its quality indicators. This system creates a set of standards and marks the degree to which the care provided meets those standards. The monetary element serves to underscore the meaning of this kind of care and further stabilise the achievement of that meaning through fluctuating penalties and rewards.

The NCHC includes multiple definitions of care, and multiple links to other stabilising mechanisms, like the price for care and the incentive and penalty system. But, what is stabilised through this document? Is it care? Is it the idealistic and abstract idea of care as put forth by the Care Standards that focus on dignity, choice and equality? Or is it the quality of care as presented by the Care Inspectorate, which looks to the quality of the environment and leadership within the care home?

The NCHC was designed to meet to the information needs of local authorities and care homes to standardise a price for care and create clear terms and conditions. The NCHC stabilises the care home system by defining the meaning of care and establishing clear responsibilities around the provision of care. The document uses a set of mechanisms to do that stabilisation work. It inscribes a hierarchical definition for care in the text, creating categories for care and boundaries around different levels of need. It further stabilises these categories by linking them to the stabilising device of money — a fixed concept which is easily translated across different contexts and systems of meaning. These categories are also linked to legislation and eligibility criteria — external documents which serve to reify the notion of care presented in the document. Stability is further increased through the improvement exercises of quality incentives and penalties. The negotiated agreement between local authorities and care homes to produce a NCHC document is the first moment of stabilisation. The formalisation of a hierarchical idea of ‘care’ attached to a stabilising price is the second moment of stabilisation. The use of financial incentives and penalties is the third moment of stabilisation.

“IMPOSSIBLE WORK”: EMOTIONAL AND ETHICAL DRIVERS FOR THE NCHC

In this final section, I move back to the drivers for creating the NCHC and unpack some of the hidden needs within the sector as they were described to me by one of the document’s original framers. In this section, I suggest that the rational/technical drivers which I have described above were just part of the story. Faced with the “impossible work” of their day-to-day practice, contract managers also sought to create stabilisation in the sector by standardising their relationships with providers. In this section, I draw upon my conversation with Harry, one of the original engineers of the National Care Homes Contract. Harry was passionate about the NCHC and has spent the latter part of his career

championing the use of negotiated, national, framework agreements in social care. In our interview, we discussed the rationale for creating this document and the work it was designed to do. In exploring this conversation, I show that the production of a contract was prompted by a set of emotional needs as much as the rational/technical concerns for standardisation of price and quality.

At the beginning of this chapter, I suggested that the design of the NCHC sought to address the two key issues. In the first instance, it create a standard price and mechanisms to improve quality (a contract with proscribed levels of staffing and an incentive/penalty system). In the second instance, the NCHC created a contract for those local governments that did not have the resources to design or update one of their own. But according to Harry, there were other underlying drivers for the creation of the NCHC.

In particular, there was the need to reduce the workload of the contracts managers. Harry described to me the ways in which contracts managers struggled to work with the different contractual paradigms. Harry has experience as a contracts manager and was then promoted to be the manager of an entire contracts team in his local authority. He has a depth of experience with the work of contract managing as well as an overview of the care system through his managerial work. As one of the writers of the first draft of the NCHC, he was part of a team of local authority contractors and care home managers. His drive to create this contract was informed by the experience of that “impossible” work; work which involves knowing and managing details of different local authorities.

Before the NCHC, each care home had a different way of contracting and different terms and conditions for the care they provided. This was exacerbated by the differences between local authorities. Under the Community Care and Health (Scotland) Act 2002, individuals have the right to live in any care home in the UK and still receive public financing for their care. Contract managers need to manage the different fee rates, patterns of contracting and relationships with the care sector in each of the different local authorities where their own local residents may decide to move.

Harry: So you set one standard for your homes in [your local authority] but the one down the road has a different standard. How do you justify that? And you know that a third of your older people have actually moved down to there because it's just an arbitrary Local Authority

boundary — so it makes no sense to have different systems.

For Harry, the “resource implications” of doing these different kinds of contract work are central to the problem. Attempting to manage different contractual realities is, quite simply, an “impossible” task.

Harry: The resource implications of trying to do things locally are incredible. You've then got a problem, right, with quality and price because most local authorities are placing lots of people across borders. People can choose anywhere in Scotland or in England. Councils before the National Care Homes Contract had to have hugely complex cross border cross placement arrangements cause in each case – say if they went to Aberdeen, were they going to come under Aberdeen's contract? You're going to have to then work that out under your own contract in which case you'd have to negotiate for each placement elsewhere in addition to negotiating for each placement in your own area. Impossible, it's just impossible.

According to Harry, a principal component of the NCHC document is the “national” focus. It provides a framework for the management of care homes that can be used by all 32 local authorities. The importance of this is best understood in light of the work that 32 different contractual contexts required. Harry suggested that there was an “enormous backlog” and “impossible” levels of work. Cooperation and collaboration reduces the workload of the contract manager. In turn, this allows the ‘care’ for older people to come to the surface. When the workload is impossible, this care is lost. Here, Harry emphasises the “huge” improvement that this framework created in the process of care delivery which the local authority contract manager carries out.

Harry: What the framework has done, and it is a huge benefit, was to deal with all those cross-border placements. It's dead easy now. Now you have a letter saying you're placed on the National Care Homes Contract which is issued by the Local Authority in the area of concern. It's cut all that hassle out and it means that you can say to your older person “you are choosing care”. When you're choosing care you can go to anywhere in Scotland and these are the set of standards and things you can expect you don't have to go and check it and say well it might be different in this area so from an individual choice perspective that universalisation I think has had enormous benefits for people. And you know that was a huge, huge, improvement.

Harry's story put the creation of the NCHC document in a new light. His account of the ‘impossibility’ of his work was a palpable part of our conversation. In this interview, the NCHC is much more than a technical document designed to fix care home prices and

quality indicators into the practice of care home services. It was a tool designed to shore up the beleaguered practice of local contract managers and ensure that the older person accessing support is able “to choose care”. For me, this suggests a desire to move beyond the paperwork and do the work of moving people into care homes successfully. Harry is aware of his responsibilities to older people and the implications of his practice. Too much paperwork and too many different ways of doing contracting was not only unmanageable, it was getting in the way of that responsibility. It seems that among the various logics for the design of the NCHC was the need to respond to “impossible” workload of contract managers.

The NCHC has produced real moments of stabilisation in the sector. It standardised some of the workflow for contract managers, created a national contract which all local authorities can use in their own local care market, and it has created some clarity for people accessing support. As Harry says, it was a “huge improvement” on the way local governments used to work. In our conversation, Harry indicates that this improvement was in part the work of a “chance” set of supports which arose in 2007 when the first NCHC was drafted. I conclude this section with a brief insight into the supportive mechanisms that enabled the NCHC, suggesting that negotiation work and production of a text like the NCHC requires particular conditions for its production.

The national framework attempted to create an explicit, and discrete, space for collaboration. Prior to the NCHC, local authorities depended on the work developed in one or two contexts.

Harry: What originally happened contractually was you had Local Government re-organisation in 1995. Before that you've got regions and when Community Care was introduced 1993, care home markets started growing places in like [anon name of council]. So [that council] developed their own care home contract alright and that contract was still around 8 or 9 years later after that region had gone. Actually because it was one the biggest regions, a lot of people used their contract even though it was a very, very basic contract. It had been put in place quickly – they were good at doing things like that. Then one or two Councils had started to try and develop their own contracts, but when it came to the point of the National Care Homes Contract people knew across Scotland that most people had very out of date contracts. The couple of councils who had been trying to update their local versions — well basically that experience was used.

In our conversation about the development of the NCHC, several features of the environment were revealed to be fertile for developing the document. First, Harry suggests that working “jointly” is not always viewed as valuable. In this case, Harry had support from others in the organisation, most importantly his manager.

Harry: Actually my experience of other joint things like this is that you keep putting appeals out to different Local Authorities but who you get to volunteer — who’s allowed to join in by their manager and whatever — all those things you know come down to a bit of luck. I mean my um my manager at the time [of the NCHC] was really supportive of me being involved. They thought it was a good thing — that it would help sort [our Council’s] problems. But you know, equally you have people saying “no you can’t get involved in that — your priority’s local”. There’s a lot of chance in it.

Harry’s comment about “chance” suggests to me that this kind of support is unusual. Having a supportive manager who was interested in system-wide problems rather than just local priorities was both enabling of the process of working and the NCHC and a matter of luck. Harry talks about “chance” again when describing the variety of input which went into drafting the first NCHC in 2007.

Harry: I mean from COSLA’s point of view it was a pretty good chance. You know, they asked local authorities and there were two or three people who happened to be wrestling with contracts who heard about it grabbed the opportunity and wanted to get involved. From the providers side, interestingly, there were a couple of people who really understood their systems and some of the problems who wanted to be involved.

A supportive manager for Harry, and some support from COSLA and the private sector, were some the resources which enabled the production of the NCHC in 2007. The implication of this series, or chain, of care work is that one kind of care opens up the space for another kind of caring work to occur. Support for the idea of meeting the needs of others — for the attempt to solve a problem — is just one stage in a care chain. The production of the NCHC, as I have depicted it, was a result of particular needs in the sector: a need for stability of price and quality and a need for an ongoing, stable, relationship between the care home sector and local authorities. But there were other needs at play here: the need to support the unmanageable work of contract managers and ensure that there is enough clarity of the system so that when people accessing support “choose care”, they receive it. This narrative differs from the political manoeuvring of Scottish Care or Local Government’s chronic failure to fund care appropriately. Instead the account I have

provided here describes a beginning that is focused on the desire to support the giving and receipt of care.

DISCUSSION: CONCEPTUALISING THE NCHC AS A BOUNDARY OBJECT

From the perspective of these participants, the document offers some measure of stabilisation to the sector by fixing the price of care home fees at a national level and the tying of quality standards to a penalty/incentive system which promotes quality of care. These are technical mechanisms of stabilisation — prices and quality measures — manifested within a technical document. Another driver in the creation of the NCHC is the need for an ongoing ‘stable’ relationship. The contract binds the representatives of local government (COSLA) and the private sector (Scottish Care and COSLA) into an on-going relationship that is re-negotiated year-on-year. Although these negotiations are fraught with the sense that one party or another will walk away from their on-going agreement, the relationship remains intact. Behind the technical and relational needs, and their corresponding mechanisms of stabilisation, is a story about “impossible work” and the “chance” supports which helped to solve it. This account suggests that the NCHC was a response to more than the technical needs of care sector to manage its activities, and more than a ‘trade-off’ to keep everyone happy and working together – there are emotional and ethical needs here too. Contract managers were overwhelmed by the inconsistencies in the sector and this was preventing them from meeting their responsibility.

I have suggested that that the NCHC as a boundary object (Fujimura 1992; Bowker & Star 1999; Star 2007). Boundary objects, by their definition, sit between two spheres. These may be spheres of knowledge or practice. They may be implicit or explicit area of activity and the boundary itself may be known or unknown. At their core, boundary objects are communication devices (Star & Griesemer 1989) and so anything that does the work of communicating can act as a boundary object. For Star and Griesemer (1989), a boundary object may be as obvious and notable as the California border. For Carlile, it may be the blueprint for a design. For Koskinen and Makinen (2007), it might be a contract similar to the one I examine here. These variations echo Star and Griesemer’s (1989) suggestion that a boundary object should be plastic. This plasticity allows it to adapt to the context and the user. And yet it must retain some element of consistency throughout its work so that key elements of its construction remain fixed regardless of location or interpretation.

The NCHC document takes on a variety of the attributes of boundary objects. It sits between two spheres of practice and is a product of the “information and work” requirements (Star 2010, p.602) of local authorities and care home. As a framework agreement, it functions as both an abstract and ill-structured object was designed to bring together 32 local authorities and approximately 911 homes in Scotland. As a local contract for services, it is more concrete and structured. But it also resists elements of this definition. This chapter articulates the work that the contract does as well as its production and re-production as a boundary object, in order to consider the stabilising influence of boundary objects. It takes on Star’s interest in cooperation without consensus and explores ‘what’ meaning is shared and ‘why’.

Interestingly, in Star and Griesemer’s early account of boundary objects in the zoological museum, the creation of a boundary object was designed to *support* communication across diverse fields of knowledge and practice and *enable* a streamlined way of working for the community of practitioners in the museum. This supportive and enabling work of boundary objects is echoed in Harry’s account of “impossible work” and the “chance” supports which enabled the creation of the NCHC. I find harmonies here between Star and Griesemer’s interest in the museum manager’s supportive approach to the practices of traders and scientists and the original framers of the NCHC’s need to support transparency in the on-going relationship between care homes and local governments.

The NCHC stabilises the care homes sector by stabilising the relationships between local governments and care homes in an on-going contract through which each party agrees to work together within the parameters of the document and re-negotiate these parameters year-on -year. The framework agreement/contract stabilises the price for care home placements and the relationship between the two parties. It also stabilises the web of meaning of around the concept of care. It inscribes a definition for care which is hierarchical and links that definition to the stabilising device of money as well as legislation and the guidance on eligibility criteria. These are the first two moments of stabilisation it offers to the sector. They both reflect the activities of national policy actors (COSLA and Scottish Care) and sit firmly within the realm of policy creation. For the contract is more than just a document to name responsibilities and consequences; it is a national framework agreement which means it binds each of the 32 local governments

and all of the private sector care homes into this relationship. Although it deviates from the artefacts of traditional policy making (legislation, guidance, etc.), I suggest that, for Scotland, this document is the primary policy making device in the care homes sector. It determines at a national level the kinds of care that will be provided and responsibilities of different actors within the policy space (local governments, care homes, people accessing support).

But how is this document implemented in practice? How are the stabilising tactics, so carefully inscribed in the text, manifest in the day-to-day realities of managing the contractual relationship and providing care? Does the contract really solve the problem of “impossible work”? Does it really create a stable relationship between care homes and local governments? These are the questions which I explore in the following chapters, first looking to the realm of contract management and then to the response of local care home managers using the NCHC text. As Smith suggests, the “diverging and conflicting concerns can be negotiated in the production of a text in which the divergent views no longer appear” (2001, p.176). As I go on to show in the following two chapters, the implementation and use of the document have an impact on the relationships and the continuing production of the care system, and some of the differences that appeared in the framing and assembly of the document come out again as it is translated across local governments and care home practice.

5. IMPLEMENTING THE NCHC

INTRODUCTION

In Chapter 4, I provided a window into the creation of the NCHC document and the stabilisation that it produces between national policy actors in the care home sector. The work to make and re-make this document was depicted as a process of negotiation that stabilises the relationships between COSLA and Scottish Care through the production of a national framework agreement. I also gave an account of the three central stabilising mechanisms in the contract itself: a hierarchical definition of care linked to price, a fixed fee scale for care services in Scotland, and a quality incentive/penalty system. In that discussion, I highlighted that the NCHC is a template for all Scottish local authorities which needs to be activated by local governments and adopted by local care home providers in the 32 councils in Scotland. It is this activation and enrolment that I explore here.

When enacted by local governments, the NCHC brings with it certain kinds of work. This work is broadly termed 'contract management', and, as I will show in Chapter Six, it is contested by those who work in the care home sector. While the terms and conditions of the contract might be deliberated and debated before they are fixed in writing, the interpretation of these terms is not set and the boundaries to contract management are not agreed. Contract managers are seen to be responsible for managing these terms and conditions, but much is contingent. Some of their work depends on context and relationships with others in the care sector such as the care home and the Care Inspectorate. At other times, their work is dependent on colleagues within their own local authority or neighbouring council. This chapter explores the contingent nature of some of this work and the boundaries of its practice. The crux of this examination is the everyday work that people do to manage the contract and their own accounts of its meaning to the sector.

I have divided this chapter in three sections: text work, relational work and emotional/ethical work. I present perspectives for four contract managers in Scotland: Michael, Sarah, Steven and Penny, each of whom works for a different Local Authority in

Scotland. Our conversations began with an overview of the work they do, and were in large part directed by their own account of the day-to-day tasks they undertake as part of their job. Where relevant, I draw out the emotional dynamics of these conversations and show the emotional labour which seems to underpin the work to stabilise and translate meaning.

AN OVERVIEW OF CONTRACT MANAGEMENT WORK

Contract managers tend to work in small teams or alone, depending on the size of the council. Most contract managers had a variety of different service contracts to manage. The National Care Home Contract was a significant part of their work, but it was not the only contract or service they monitored. In addition to care homes, the contract managers who I interviewed were also responsible for other care services, such as care at home. While I use the term 'contract managers' throughout, the individuals included here often had different jobs or roles in a contracts department. Some of them were managers of a contracts team while others hold the position of the resource workers within a team of contract managers. In each case, they had the chief responsibility for managing the day-to-day operations of the National Care Homes Contract and thus were most familiar with the work it requires. There is a set of activities which make up the 'work' of contract management. This is technocratic work. It uses technical language. It is contained within the confines of governmental organisations and private companies. It attempts to use objective measurements to quantify and calculate activities like 'performance' and 'quality' and it is carried out by people who are experts in their part of the market for care homes. For these contract managers, their everyday experience is technocratic. But that is not all it is — this work is imbued with feeling. Contract managers talked about the importance of mutual support in carrying out their work as well as their anxieties about the care homes sector and the older people who rely on this kind of support. For these four people, at least, contract management is not just a rational-technical activity. It is emotional and relational as much as it is technical. This is a reflection of Hochschild's "sentient self" (1983) who brings an "emotionally-sensed knowledge" (Hubbard, Backett-Milburn, Kemmer 2001, p.120) to their everyday activities.

The excerpts I present here offer a glimpse into these four contract managers' personal understanding of the work they do and the relationships they maintain as part of their job.

In their work with the NCHC, they need to ensure that the links between the fees paid for care reflects a care home's quality grades (as determined by the Care Inspectorate). It is this work which sustains the stabilising mechanism of 'price' which is created by the NCHC's framers. This work with care homes to capture their quality ratings and administer their fee is part of the formalised relationship between local governments and care homes. But there is more to their relationship than just "administering" the fee rate. An account of the NCHC document's stabilising mechanisms and the acknowledgement that an on-going relationship is created with this text does not capture the messy complexity of this work in practice. The creation of the text is just the beginning of a set of practices. I group these practices into two kinds of work — text work in which contract managers activate the requirements of the contract in practice and relational work through which contract managers enrol and translate the contract's logic into practice.

Text work begins with the use of the NCHC as a boundary object and the activities which care homes undertake to translate it into their own practice and the practice of care homes. This kind of stabilising work has a more vertical aspect to it — activation involves fulfilling the requirements of a national framework agreement and enrollment of care homes is fraught with uneven power dynamics. Activation involves working with texts (documents, databases, Care Inspectorate grades) to ensure that care homes meet the basic requirements of the contract. This is much more than the administration of a fee rate. This is the work of risk — financial viability and critical incidents involving older people's care. This is the work of managing complex information from a variety of sources, while simultaneously identifying and plugging the gaps in those information systems. I depict this text work in a series of vignettes involving fitness checks, grades, risk and repercussions. This text work accomplishes a process of activation by enlivening the contract's logic in the day-to-day practice of local authorities. This is the "intimate knowledge" (Schmidt 1993) of the everyday. The NCHC text cannot be extracted from this knowledge and practices in which it is embedded. To paraphrase Smith, texts are situated in and structure the social relations in which people are actively at work (1990a, p.163). This work is embedded in the geographies of their local authority, including the market for care homes, the politics of the local council, the distances between communities, the density of populations in these spaces, and the cultural-religious dynamics of the people who live there.

Relational work involves the translation that contract managers do to bridge different spheres of practice in order to enact the contract's requirements in practice. This is the work of balance — there are conflicting policies and practice in this sector and contract managers need to make informed decisions which take these conflicts into account. This is the work of shared experience — contract managers work together to grapple with some of these complexities. It is the work of using one's own discretion to parse out a response to conflict. I depict these activities as interpretation, developing shared meaning, using discretion and "re-translation". Translation work accomplishes a process of activation through the enactment of the document into the day-to-day experiences of contract managers and care homes. This is the realm of decision making — and with each new interpretation and act of discretion the contract is re-made in the day-to-day practice.

TEXT WORK: ACTIVATING THE NCHC

The terms and conditions of the NCHC require evidencing, and contract management work is in large part the collection and management of that evidence. This information can take different forms and come from a variety of other actors or locations within the sector. Contract managers might seek to verify certain documents which evidence the legitimacy of the care home. They might also access a website to download, and read a report to do their work. Or they might read emails from a colleague in their organisation. Information can come from a variety of places. And so contract managers tend to belong to sector-specific mailing lists about the care homes market and gather information from the messages circulated in that virtual space. They might access a database to look for specific details about care home providers or the care that they delivery. In particular, they might be interested in the prices of care in other parts of the UK.

Contract managers rely on their networks within the sector to direct them to information. Contract managers might phone someone in another local authority or other organisation to access the information they need. They might go to a meeting or speak to a colleague at work. They might read about care home provision in the newspaper or hear about it through the news. They might have a family member in a care home and may come across details of care through their personal, non-professional, contact with care homes. These networks might be formal communities of practice or informal peer-support systems. The stabilisation work that contract managers do relies on these systems of support to shore

up the technical information systems they manage. In working to ensure that the contract's requirements are met, contract managers use locally developed tools and databases to capture and manage information. These tools are not perfect; contract managers described the gaps in the information they collected and the challenges of managing that data in the everyday. I draw from my conversations with Michael, Penny, Sarah and Steven to give some insight into the different kinds of text work they do to manage the NCHC.

MICHAEL AND "FITNESS CHECKS"

Michael is responsible for the NCHC along with a series of other service contracts in his council. We talked about his contract management work in terms of information he is required to collect and the tools he uses to manage that information. For Michael, contract management begins with a process he calls "baseline" or "desktop" monitoring. This process is focused on managing the specific information that is required to evidence the terms and conditions of the contract. When Michael does baseline monitoring, he is looking for a set of "supporting" documents which are required by the NCHC.

Michael: In light of The National Care Home Contract, there are a whole lot of requirements that we would look at. We use a lot of monitoring measures. We will normally do baseline monitoring, which involves checking documentation. This includes basic supporting documents for the contract like insurance, registration, financial statements, and the operational policies. So generally that's what we will check.

In this account, Michael indicates that part of his work involves a process of "looking at" and "checking" documentation. His verification of these documents confirms that the care home is meeting its requirements. By "checking" for appropriate documentation, such as evidence of indemnity insurance or the mandatory registration with the Care Inspectorate, Michael confirms that those processes have occurred.

In its simplest form, document work involves the collection and "checking" of documentation. To manage this work, Michael has designed a tool to help him with this work. This tool allows Michael to do a "fitness check" of care homes. In this description, he outlines the requirement that care homes "confirm" the existence of the required documents, as well as features of the care home's performance and financial standing.

Michael is clear that he must also “prioritise” the information that he collects from Care Homes.

Michael: What I normally do, is to uh, ... (looks through papers) send a form around annually and when required —

CR: — to the providers?

Michael: Yep, to the providers. A form like that (shows me the form)

CR: And did you develop this tool as well?

Michael: Yes, and we use it to do a fitness check. [The providers] have to complete these requirements just to confirm that they have all of these things in place. Though in retrospect it only gives us a hazy idea of their finances, I don't know if you're aware—

CR: Southern Cross, yea

Michael: It went out just like that. It's sad that it's quite difficult to notice it financially. But, at least the form gives you an idea of what's happening and then you are prepared if a care home is going to be closed down.

In this passage, Michael provides a more nuanced picture of his document work. This tool is designed to evidence whether care homes have accomplished their requirements within the NCHC (e.g. registration and insurance). But this tool is less useful when Michael needs to show more complex aspects of care home provision. When Michael engages with documents like financial statements and operational policies, his text work might require more than verification. While the existence of some documents is enough to meet the requirements of the contract manager and the NCHC, there are other kinds of documents that need to be read and interpreted in addition to being “looked at” and “checked”.

Importantly, he also reveals that his document work has limits. When dealing with documents like financial records, his document work only gives him a “hazy” account of the meaning contained in the documents. Michael's language directs our attention to the subtle emotional undertones of this limit — “it's sad that it's quite difficult” — a charged descriptor of the nature of this work. These limits have implications – particularly in light of the (then) recent Southern Cross failure. This is not just the rational work of a technocrat — there are feelings here and Michael's sense of the limits of his work bring more to the surface than the mechanical identification of a gap which needs to be filled.

Through Michael's monitoring work, we also see some of the work that the NCHC requires from care homes. His document work requires that care homes participate in the document collection and verification. He describes that the council "will ask" or "will require" the documents that come out annually, such as confirmation of insurance and registration. In practice, looking and checking for documents requires that the care home present these documents for inspection.

Michael: In terms of records — we may ask the provider to provide certain records for examination, and we expect them to keep records of all of the activities that they do in the care home.

Michael is clear that he must also "prioritise" the information that he collects from care homes. Michael's document work is designed to verify on an annual basis the supporting documents for the NCHC. Baseline monitoring is a kind of "basic" monitoring. Proof of these documents provides confirmation that the care home has fulfilled the basic requirements necessary for its operation, such as insurance and registration.

Michael: So, we try to prioritise our monitoring — in the light of limited resources y'know — and do basic monitoring for all. I mean baseline monitoring for all providers, no matter what. That involves checking out normal standard contracts supporting documents, normal insurance, indemnity, financial viability, things like that, for all providers.

Monitoring for Michael brings with it a set of "expectations". In working with these expectations, his activities have an evaluative dimension. The degree to which these expectations are met (or unmet) requires a reaction from the contract manager. In part, that reaction is prescribed by the mechanisms outlined by the NCHC which Michael is contractually required to deploy in response to his evaluative work. These mechanisms are often contested. For Michael, they can involve negotiation and, from his perspective, a kind of development work which helps to ensure expectations are met.

Here are some of the expectations Michael discussed in our conversation:

Michael: We would normally expect providers to develop a brochure which will specify care home fees and what they do to get people in their homes and what fees they charge and things like that and then we will expect them to put into place individual residency agreements.

Michael: We also expect all care home managers to be registered with the

SSSC or the NMC.

Michael: We also expect care home staff directly involved in care delivery to have qualifications at SVQ Level 2 or above. We look for — as a minimum — that sixty-five percent of staff should have that qualification.

Michael: We would also expect them to get certain grades from the Care Inspectorate. At the moment they should have Grade 3 or above to get the basic fee. Then when they have Grade 4 or Grade 5 or above they get an enhanced award, which is only between a pound and three pounds, so depending on what grades they have, we apply extra pounds — we pay pounds.

The activities of care homes, and the experience of those working and living in them, are evaluated against these expectations. Most of Michael's expectations are based on the terms and conditions of the contract document. While the language of the contract document is one of requirement (terms and conditions), Michael's language is that of expectation. In expecting care homes to meet certain standards, there is an appreciation that they might not meet these objectives.

Michael details the flexibility of his expectations in this excerpt about staffing requirements:

Michael: They should have the qualifications in order to be registered so that will probably solve the problem of any unqualified staff. But we acknowledge the fact that there are experienced staff out there who do not necessarily have the qualifications — but they may have very high standards because of their enormous experience — so we may be flexible on that.

Continuing on in this discussion of staffing requirements, Michael extends his flexibility around expectations to an explicit desire to help and support care homes to meet their contractual obligations:

Michael: Sometimes considering a lot of realistic factors we will allow a dip in staffing qualifications — unless it's far below sixty percent — then probably we will sit down to see how we can help them develop staff to the level that we were looking for. It's not always 'just do it' — just take the penalty — but we find ways to help, especially when certain care homes have had problems recruiting staff or things like that.

Michael's expectations of care homes are informed by both the requirements of the contract document as well as his experience with the care home sector. He is aware of some of the difficulties a care home might face in terms of staffing, i.e. challenges with recruitment. His work with expectations involves both flexibility and support – and his aim seems to be a desire to 'help'. This is a subtle, but significant, orientation. Michael's work enacts a set of expectations from the NCHC text, but it is also grounded in his own supportive approach to care homes. Expectations and a desire to help go hand-in-hand here — suggesting that the work to enact the NCHC is both rational-technical and something more: there is an emotional dimension, an element of empathy to his work which seems to affect his discretion in applying his monitoring work.

Michael's work brings the NCHC text into being in the local context. His work as a contract manager enacts the inscribed logic of that text. It is the vertical stabilisation work of pulling in the facts and figures that the NCHC demands. Within the account of Michael's work presented here, care homes are entities which require "things" like registration and indemnity insurance. His work to collect information is designed to verify their 'state' of being registered and insured. In this way, he enacts the terms and conditions of the contract's text and stabilises its meaning in practice. This stabilisation serves to ensure that certain "basic requirements" are met within his area of the care home sector. But there are gaps, instabilities, in this work. Not all of the necessary information is collected.

PENNY AND "GRADINGS"

Penny is a resource manager on a team of contract managers. As the resource manager she is responsible for the day-to-day work of managing the NCHC. Like Michael, she collects and uses information from external organisations such as the Care Inspectorate to do this work. She also collects information from other sources, such as members of her team or others in the council. Like Michael she was also conscious of the limits of some of this information. She was conscious throughout our conversation about the limits of her own work and often referenced others on the team who might know more about a specific area. My conversation with Penny was very focused on managing information. We spoke in great detail about the different tools she uses to access and manage information about care homes. Here too, there is a process of "looking at" and "checking". In order to manage this information, Penny uses a set of tools such as the Care Inspectorate datastore

which holds information on performance, and inspection reports from different care homes across Scotland. As discussed in Chapter 4, the NCHC document uses the Care Inspectorate's grades to determine the price care homes receive for the care they provide. Good grades, a five or six out of six, will mean that care homes receive the "enhanced quality award" for each publicly-funded resident in their care home. Poor grades, a one or a two, will mean a deduction from the basic rate.

Penny: One of the biggest things which actually takes up — can take up quite a lot of time is um dealing with the financing. So what I'll do we keep a record of the Care Inspectorate grades that our homes grades. Admin send it out to me I think every month, so I'll check that and look at whether homes have poor grades. This might mean in the future that they might get some money deducted from the fee rate. Or they might actually be on a lower fee rate and have got a good grade so they might get their fee put back up to the basic level — so it's a lot trying to keep on top of that. Because a care home will 'phone you up quite readily if they've got a good grade wanting the enhanced quality award but see if they've got a bad grade they don't 'phone you up as often to say that I might actually be getting money deducted that kind of thing so that's a big part of my job is keeping on top of all the finance stuff and it can be quite complicated.

Penny's description provides some insight into the implications of sharing information. The Care Inspectorate's grades are a determining factor on the price care homes receive for the care they provide. Good grades, a five or six out of six, will mean that care homes receive the enhanced quality award for each publicly-funded resident in their care home. Gathering and sharing information in this context is bound up in a set of financial repercussions. As Penny suggests, care homes are quick to call if the outcome of their grade is a positive one, and less quick to phone if it means a deduction. Here, again, we see the way that contract management work is inter-connected with that of care homes and the Care Inspectorate.

We can also see the work that Penny must do to engage with other councils. As she says, her council has placed numerous service users in other councils. This is a common enough occurrence. People might be funded by one council but receive their care in another, usually because it is closer to their family. It is Penny's job to determine the cost of their care and ensure that appropriate payments are made. In this way, we see the way Penny's information work is a necessary part of ensuring that care homes receive the correct payment for care. Gathering and sharing information in this context is bound up in a set of

financial repercussions. The financial element stabilises the quality criteria with a financial penalty and incentive system. But information is not collected, managed and shared perfectly. It is done inside an existing set of relationships. As Penny suggests, “it’s a lot trying to keep on top of that” relationship work. There is effort here to make and maintain these relationships so that information flows well between them. The implications of this information sharing has impacts on the way that Penny manages information. Care homes tend not to notify councils if the grades have been poor. Penny describes her strategies for finding difficult information.

CR: I’m interested in some of the tools that you use — for example the Care Inspectorate datastore. Is that something that Local Authorities can log on to?

Penny: Yeah — it’s available through the Care Inspectorate. It’s pretty much a spreadsheet. What I normally do is — you can print it off for all of Scotland but I only do that when I’m doing quarterly reports to compare the performance of [our] homes to the rest of Scotland. But you can also print it off for just your local authority and it’ll list all the services – not just care homes, but all the services that are registered with the Care Inspectorate. It will give information on what the service is — how many places is it registered for — the address, provider name, all that kind of basic information. Then it will give you their latest grading and also anything like an action plan that they’ve asked to put in place and any details kind of issues that have come up like complaints and things like that. I don’t really look at that that much cause it’s more the senior officers that would be interested in that.

CR: But for your purposes the bulk of your interest is in the grades.

Penny: The gradings, yeah.

In discussing these tools, Penny highlights the breadth of information that is gathered: basic information, grades and relevant action plans in response to poor grades or incidents. Not all of this detail is used in her work, which gives some insight into the focused nature of her particular kind of information work. Penny is interested in the grades because the grades make up a central feature in the contract management work. Aside from the financing and price aspect of the grades, Penny is also interested in the performance of her local care home sector compared to other areas in Scotland. This gives some insight into the embeddedness, the localness, of the care home sector. Penny’s work is focused on her local authority, and whether that means supporting local authority

service users to live elsewhere, or keeping tabs on the care homes in the local area, there is a very clear local focus.

Penny also draws my attention to the limits of these tools:

Penny: I think there's a lot of work needs done on it.

CR: Is it a new thing?

Penny: It's not a new thing but there is a new team looking at it trying to improve it because the problem is that it only gives you what they did that quarter. It doesn't compare it with what they did last quarter like any benchmarks for care ...

CR: So it would presume that you know or are able to compare?

Penny: Yeah yeah and that's one of the problems — that's one of the things that the team's looking at ...

Managing information has implications and limits. Care homes receive higher or lower weekly payments based on the information that councils collect from the Care Inspectorate. This information sharing has impacts on the work of managing information. Care homes tend not to notify councils if the grades have been poor and so Penny develops strategies for finding difficult information. These activities are not neutral. Information is not collected, managed and shared perfectly. It is done inside an existing set of relationships, and likely has a hand in creating the dynamics of those relationships as well. Penny's work to "hook in" (see Smith 2001, p.164) care homes and their operations is part of the vertical work to activate the text and enroll care homes. But the tools that are used to support this management have their own limits. The contract management framework used in Penny's council lacks a sense of time and history. It is too narrow in its focus and does not allow her to track changes over time. Improvements are being developed, in conversation, by the team. Like Michael's account of text work, information work is a social activity. The improvement of existing tools and processes is done through discussion. The sharing of information is dependent on the work and actions of others in the field.

SARAH AND RISK

Sarah is a contract manager in a larger local authority. This means she works in a team of contract officers so she is able to seek support from an internal network of experienced professionals. But it also means that she has a lot of care homes in her area and a lot of people accessing them for support. For Sarah, contract management involves managing information, and this is very much a shared activity. Tools are developed by the team. Information is shared at meetings and in local forums. Other contract managers provide invaluable guidance and support to interpreting this information. The “shared experience”, as she terms it, of contract management, is one of the high points of the work. There is support and knowledge which can be accessed from the community of contract managers who work with the NCHC. There is also support and understanding from others in the council who work on services for older people. Contract management also involves observing and evaluating the work of provider. Her work involves managing the indicators of performance, as these give her a sense of the risk that a care home might be providing poor quality of care.

Sarah: I check — quality wise — those homes that are performing so we know if there are issues with them and whether we need to go in and review our residents’ care needs there. So that gets done every month. We monitor the homes across the council with a general level of risk indicators and then every six months we do a kind of full audit of all the contracts. It’s quite an in-depth risk assessment ... so that’s kinda how we keep a handle on the performance of those homes.

Her council has developed a coding system to help them categorise care home performance. Sarah seems conscious that care homes may need support if their performance is poor.

Sarah: In [our council] we monitor our care homes with [a database]. It uses a traffic light system: red yellow and green. Green being everything is okay and we've got no big issues there. Amber is we kinda need to keep an eye on these ones and red indicates that there's issues that we know about so we've got to go in and do something — set up a meeting and talk to the home and things like that.

Managing information in this council depends on the use of two different tools: a client information database and a care home performance database. When we talked about how Sarah manages risk, she was careful to point out that the tools she uses have different, but complementary roles. These two tools reflect the dual focus of contract managers. The

contract document which they manage encompasses both the individual and institutional. At the organisational level, they are interested in reports about the organisation's performance. But the payment mechanism that they use is oriented to individual care home placements.

Sarah: Our risk process has actually been created on an Access database by one member of our team and he's created a separate database that sits beside the [client management] system. If you like the [client management] holds all the client information like case notes and stuff like that and it also holds financial information for invoicing purposes and our system is purely a contracts system for managing risk in contracts but the [client management] information feeds into it so that we're you know we're running two separate systems; we are actually using information so that we've got a kinda broad picture.

I asked Sarah about the Access database that they use and she explained that this was designed by one of the members of the council's contracts team.

Sarah: Yeah we're really lucky we've got a member of the team who is really skilled in that kind of stuff and he created it himself and set up lots of different reports that can be run from it so you can run a report on all of the contracts — so you can see where the red, the yellow and the greens are at a glance — or we can just run individual reports on specific services, yeah it's a useful tool um it takes quite a while to do a full audit every six months, you can imagine we've got over 600 contracts — to go in and checking things like Care Inspectorate grades, checking complaints, any adult protection issues, contract start and end dates, unit costs, you know, sort of price information, costing — so that's quite intense.

Like Michael and Penny, Sarah needs to collect information from a variety of sources across the sector: Care Inspectorate grades, complaints from service users or their families, adult protection reports, price information, and so on. Sarah's account gives some insight into the challenges that managing this information brings. Her work is "intense" work; it involves trying to manage the risk that the quality of care provided will be poor. It means being on top of all the different care homes in her area and the different dimensions of information that are related to the care they provide. The work of pulling in care homes, of 'hooking' the council and the care into the logic of the NCHC is intense — it has an emotional weight to it as well as a set of technical challenges.

STEVEN AND “RAMIFICATIONS”

Steven manages a contracts team in a small local authority in Scotland. He is responsible for all the service contracts in his area and leads on the NCHC for care home services for older people. Contract managers juggle the work of evidencing the contract amongst a range of other duties. When I asked Steven to describe his day-to-day contract management work, he talked about “the screen” which refers to the calendar system which his department uses to manage their shared workload. In talking through the work he does to manage information and evidence for the NCHC, Steven also talked about his other work to de-commission services and meet high-level policy agendas.

Steven: The screen brings up a different agenda every day and you can't quite predict that, however, what fits the diary on top of that is the fact of there will be key meetings that we [our team] attend. So yeah looking at some of this stuff — there will be the meetings with the care providers which we'll go to, the reference group and things like that cause we're on the reference group etc. You know the [reshaping care] agenda will run and we know which bits we're responsible for so we have to fit those agendas. There will also be a programme of tendering so we'll also be involved in those. We will also have other big agendas that we'll have to pick up and all of us will at least have one major re-engineering project that we will be involved in and there'll be a project team for that. There's also de-commissioning of services and you know that gets quite difficult.

The vertical pulling which draws councils and care homes into the NCHC framework is set within a wider context of the Reshaping Care for Older People agenda (COSLA et al. 2011). New services are being designed and more traditional services are being de-commissioned. Like Sarah, this work can be difficult. There are balances to be struck between the relational and text work of contract management and the broader policy context which seeks to shift the balance of care from the institution to the community, from service-led to personalised support. Steven needs to balance the “contractual implications” of a range of social care planning activities – not just the NCHC document.

Steven also talked to me about the “ramifications” of his work, with a particular focus on the areas of crisis he might be “drawn into”. His contract management work has implications, not just on the policy and planning of social care he described above, but also on the individuals who access services.

Steven: We get into disputes if people's services have been sub-standard and we've been getting complaints. If there are things that start to come

up that have contractual implications then we get drawn into that. For example, we get involved with adults at risk issues if there's been a major issue around personal finance for instance, or bad practice around a member of staff. So you get drawn into that and sometimes it's worse, some of the cases we've been drawn into have been so tragic. You can get a fatal accident inquiry and you kind of get drawn in the ramifications about this not being a robust service or you know other things.

Steven lists a series of challenging aspects of his work from complaints about poor quality of care to adult protection issues and fatalities. For Steven, these issues can range from difficult to tragic. The ramifications for poor practice and poor quality are severe. Tragic is the death of a resident or the closure of the care home. At the time of my fieldwork, there were waves of concern in the sector about the closure of one home in a local authority after the death of several residents. This closure was a high-profile scandal – featured in local newspapers and the focus of a Health and Sport Committee report by the Scottish Government (see discussion in Chapter 2). Steven's comments about "tragic" incidences also sit within this context and the Southern Cross failure. And yet his list has a slightly routine aspect to it. There are a range of incidents that might have "contractual implications" for him and his team. Tragic incidents are part of the work that he does, though I did not have a sense that this diminished the emotional weight of this work. I draw attention to the mix of routine and emotional here to suggest that for Steven the emotive dimensions of his work are not separated from the technical work that he does. Feeling work and technical work are one and the same when dealing with contracts for care.

Evidencing the contract can involve desk-based research and management as described by Michael, Penny, Sarah and Steven. The NCHC, as a boundary object, is the "common referent" (Star & Griesemer 1989, p.411) between their narratives – the shared focal point of their contract management practice. There are harmonies across different contract management practices. This is the work of collecting information and evidencing the contract. This work is dependent on a set of relationships in the sector: contract managers need care homes to supply information and they need other organisations like the Care Inspectorate to conduct inspections and apply a grading to the quality of care provided. In managing this information, contract managers bring a set of expectations to their work. They expect care homes to meet the contract's requirements and they expect them to

provide the information that is required of them, such as evidence of indemnity insurance, staffing qualifications, and building insurance.

But contract managers also indicated a flexibility in their approach to the information collected, and a desire to meet with and support care homes to fulfill their contractual obligations. Contract managers were aware that they may need to deal with unexpected events – care home closures, deaths of residents or other serious incidents are not outside the realm of their experience. In this way, they are equally aware of the ways that care homes do not meet the contract's requirements. In these particularities, we begin to see the “n-way translation” that Star and Griesemer (1989, p.412) describe. The NCHC as a boundary object bridges the practices of local government planning and management of local care home markets as much as it brings local governments and care homes into a relationship with one another. In order to render visible the vertical work of stabilisation, the local practices of pulling and ‘hooking in’, I have shown that “interface between individual lives” and the “institutional relations” of the NCHC text (McCoy 2006, p.109).

Bringing the contract to life in local contexts is firstly a text-based type of work. It is the collection of information and ensuring that the basic requirements of the text are met. But even here this “desk-based” research is embedded in a context and set of relationships. Contract managers use their discretion to interpret this context and draw upon their relationships in the sector to make sense of the information they receive. Through it all, there is a dimension of care — support to make sure care homes are successful in their obligations and emotion when things turn tragic.

This work to activate the NCHC text is relationship-based and emotional. When contract managers talked about their work, they suggested that it was “intense” work — “that it’s a lot trying to keeping on top” of the information they need to manage. When their efforts do not work, and there are gaps in the information they collect, the difficulties are more than just glitches in a system; they are “sad” and “difficult”. The emotional dynamics of this work were often too subtle to address in the research context and reflect my analysis on the research as a whole. When analysed en masse, the emotional effort of this work became clearer and the language used in these vignettes is one way of drawing attention to this dynamic. Taken together, I suggest that this emotional labour is directed towards supporting care homes: the intensity and difficulty of managing information has real-

world implications and the potential for tragedy in the sector is not so far away from contract management work. As a result, contract managers seem to feel the need to shore up the sector – a dynamic which I explore through the rest of this chapter and address more fully in the discussion in Chapter 7.

RELATIONAL WORK: TRANSLATING THE NCHC

Managing information is just the first step in this stabilisation process. As I have suggested, contract managers also interpret information in the sector based on their experiences and knowledge of the care homes in their area. They are aware of the contract document, its terms and conditions, and evidence that is required to meet these. They also know the care homes in their field and the work that they do to provide care to older people. In the following section, I look in more depth at these relational practices of interpretation and show the ways in which contract management is a negotiated process where local authorities work with care homes, and each other, to stabilise meaning in the sector. In this section, the vertical tactics of activation are replaced by more horizontal processes of stabilisation. Contract managers talked about interpretation, and negotiation, of the contract in light of the complexity of their local context and the care homes who they work to enrol. Star and Griesemer suggest that the “allies enrolled” into a boundary object “must be disciplined – but cannot be *overly*-disciplined”, thus the “reach” of a boundary object relies on the careful negotiation between the different spheres of practice (Star & Griesemer 1989, p.407).

MICHAEL AND INTERPRETATION

Care home management requires more than just the collection of information. It requires interpretation. People who do this work must bring their own understanding of that information to bear when assigning meaning to it. As Michael suggests here, the collection of information is just the beginning.

CR: Do you ever find that there can be gaps between the policy and the practice? I mean care homes may have procedures in place, but they are not —

Michael: Following them.

CR: Yeah.

Michael: Yea, yea, that's why quality assurance officers are here to go in on a weekly — even daily — basis as and when required to make sure that the gaps are identified. But, if they've got good policies that's a starting point. Like having a good qualification — that's just a starting point, but then in practice what's your performance? If you don't have the qualification, the assumption is that you may not be able to even carry out the service, so in the first place we wouldn't even allow you to enter the sector. So you have to meet some basic requirements and then we have to make sure that these requirements are up to date at all times – we've got the visits and adult providers meetings and forums to address any issues that come up in the day-to-day running of the service.

Michael describes the need to see the “basic requirements” met. Without these a provider may not be able to enter the market and provide the service. But that is just a “starting point”. Michael is also interested in the performance, in the day-to-day running of the service. He describes the various strategies the council uses to get at these details: visits to the care home and care home provider forums. These face-to-face encounters allow him to address the “daily stuff” that goes into the service delivery.

Taking account of the day-to-day running of a service implies an understanding of context — of the individuality of service providers. For example, Michael describes the difference between a service provider who “consistently” receives a mediocre grade compared with one who drops down to a mediocre grade. In the first case, the care provided is a known quantity — there is stability and constancy there. In the second case, a change in the grade is concerning.

Michael: For instance, if you have a borderline grade then that care home is not far from going below the normal threshold grading which is a three. Going below three is sub-standard. So we keep an eye on care homes who have a borderline grading. Some care homes have been borderline consistently and that's not a problem. But if a care home could be as high as maybe grade five and suddenly move down to grade three then you can see that there is potential risk there. See what I mean – there may be a serious deterioration in quality.

Michael has a deep level of knowledge about the care homes in his area. He knows the pattern of grades in the care homes in his area and keeps an eye out for changes in the quality of grades. For Michael, changes are more worrying than a consistently borderline performance. In this way he interprets the grades produced by the Care Inspectorate

according to his own experience of the care sector. But, there are challenges to interpretation. At times it can involve weighing one aspect of care against another:

Michael: The Care Commission has got four themes: quality of care and support, environment, staffing, and management. Now in terms of that we focus very much on quality of care. In the light of the NCHC, we focus on that — just for the payment. But sometimes we have to look at what is riskier. Y'know, is poor management riskier, than poor quality care? Poor management could be more of an administrative thing. Y'know, the quality of service that the care home provides could be good so maybe the manager just requires some kind of training. That's not as serious as quality of care where residents are being given the wrong medication. See what I mean? So, in terms of all that the work can be quite challenging.

Michael's work to interpret the meaning of Care Inspectorate grades reflects the complex matrix of knowledge and experience which he draws upon in his day-to-day work. It also reflects his effort to enrol care homes into the logic of the NCHC, particularly the pricing structure which is attached to the grading system. This work is knowledgeable work — it requires judgment and evaluation. This work is a form of stabilisation. Holding things together is interpretative, active: it requires the translator to make choices and fix meanings.

PENNY AND DISCRETION

In discussing the penalty/incentive system within the NCHC, I tried to unpick the way that contract managers administer increases or decreases to the standard fees for care home placements. I initially assumed that theirs was an automatic response. When a care home receives a better grade the fee automatically goes up. And if they are admitting a new resident to a care home with a low grade, they know that that care home can only receive a reduced rate for their service. But that is not quite the case. Contract managers exercise discretion in administering fees, particularly in terms of the formal penalty for low grades.

CR: I made an assumption that you could go on the Care Inspectorate website and see that if the homes you'll be using all have a grade of two they'll have the reduced rate —

Penny: Not necessarily, not necessarily — I think we'd have discretion. If they get a low grade like a one or a two, often what happens is that we'd go out and visit the home and find out why it was a one or a two and what actions they're going to put in place to increase their grades and then we would make a decision about whether to reduce their fee rates.

Discretion is central feature of contract management work. In this case, discretion performs an important function: it enables Penny to deviate from the contract's prescribed penalty. When I asked her about this deviation, Penny described the wider context of their NCHC and the role that Scottish Care plays in determining practice in the sector.

Penny: I mean we used to just deduct the money automatically but I think Scottish Care were keen that we were seen to be having a discussion with the home to find out, you know, why they getting these grades and what are they putting in place to improve it and then make a decision whether or not to deduct money.

The ongoing relationship between national policy actors (Scottish Care and COSLA) makes itself apparent here. As Penny suggests, there have been shifts in the practice of administering the financial penalty. It is now standard to have a conversation and then see what kind of support can be offered. This practice was also identified by Michael and Sarah in the accounts of text work above, but here Penny makes clear that the shift is, for her council, a response to Scottish Care's intervention. I asked Penny to explain this response to a low grade. If the penalty is not automatic, is the process of "visiting" a care home standard?

CR: Is it standard that if they do get quite a low grade, there will be immediately a visit?

Penny: There will always be a visit, but I wouldn't have said that it's all that common anymore that they're getting money taken off. It used to be that there was a lot of homes that had money getting taken off, but there are maybe one or two now. That's not a lot. But also, I think the grades have increased a lot over the last few years. There were a lot more homes getting 1s and 2s. I think the improvement is due to the possibility of getting the money taken off and the possibility of getting a higher rate if they get 5s and 6s.

CR: So [the NCHC] is driving quality up?

Penny: I definitely think it's driving quality up. I don't know about other local authorities but definitely here.

Penny's discretion is situated in the historical context of her work. In her experience, it was once standard practice to reduce the care home fee in response to a low quality grade. But now the practice has shifted and the common response is a meeting with the care

home to determine what supports are in place to improve the care provided. Most significantly, Penny suggests that in the long term these practices have supported a general improvement in the care provided in the sector. As I argued in Chapter Four, the focus on quality improvement is one of the underlying drivers in the NCHC text. From Penny's perspective, it seems to have accomplished its goal. Like Michael's account of the pricing structure above, contract managers seem to reflect some of the central concerns of the creators of the NCHC text. The work of enacting these concerns is complicated — it involves interpretation and discretion. As Star and Griesemer suggest, "such negotiations include conflict and are constantly challenged and refined" since "each social world has partial jurisdiction over the resources represented by that [boundary] object" (1989, p.412). I suggest that a contract manager's role is to mitigate those "partial" claims.

STEVEN AND TRANSLATION

The first two vignettes in this section focused on contract manager's work with the mechanisms of the contract document. I move now to the meaning the contract managers stabilise beyond the specifics of the text. Since the NCHC is enmeshed within a range of other guidance, contract managers must also work to make sense of these rules and translate them into the practice of care homes. In order to do this successfully, contract managers must make sense of different perspectives or different "agendas" in the care sector by "translating" the information to their own context.

Contract managers negotiate a web of guidance and legislation, some of which was developed years ago within a different policy and practice landscape, and almost always at the Scottish or UK-level. Part of the local contract manager's role is to translate those frameworks into local practice.

Steven: Now [one problem we have] is the determination about whether somebody is public or private [client] given their different circumstance under the CRAG rules. Right okay, the CRAG rules were written a long time ago before the National Care Homes Contract, definitely before some of the guidance on additional service charges. And now you've got references to 'top-ups' in there. The Charging for Residential Care Guidance, referred to as the CRAG rules, determines whether a person accessing care home support will be classified as a 'public client' who received local authority financial support for their care. As a private client, the person accessing support and/or their family will pay directly for the care. This guidance is at the heart of much of the care and support

provided to older people in care homes since it determines the circumstances in which local governments intervene.

As Steven goes on to clarify, the CRAG rules (Charging for Residential Accommodation Guide) have a wide, and seemingly contested, pattern of interpretation.

Steven: Now, if you asked different councils you'd probably get a different answer from each. You know, I actually did ask this when we were in a discussion with one of the reference groups with Scottish Care including the Chief Exec and the Deputy and I said can um "can you just clarify this for me: are you saying that additional service charges supercede top-ups?" And the Chief Exec said "yes" and the other one said "no" (Steven laughs).

Despite the humour of these conflicted readings of the CRAG rules, the reality for the contract manager is that they must translate this guidance into practice each time someone accesses care home support. In Steven's words, he "re-translates" information – a term which I understand as a reflection of the work that contract managers must do to bridge local policy and service delivery; this information has already been 'translated' from the national level into the local authority's practice, but contract managers must bridge the gap between local government and providers, which is why this is a "re-translation".

Steven: But, when you've actually got somebody stuck in all of this and you've got the providers split by the national organisations — the trouble is things have been legislatively or even guidance-wise dovetailed in together. Guidance has come in at different times and they don't necessarily fit — nobody's revised one against the other and therefore you've got characters like me and the legal sections trying to re-translate it all. The implication for one individual is whether they're getting charged this rate or whether they're getting charged that rate but this has also got ramifications for how the nursing home itself will operate. It looks small but it's actually quite big.

Each person receiving local authority financial support in a Scottish care home has an individual care package and fee arrangement which goes along with that care. The work that Steven does to translate these rules has real implications for people's level of financial support and their ability to access care. Steven seems to be conscious that this, in turn, has ramifications for the level of financial support care homes receive (since they are often highly dependent on publicly-funded service users).

Steven's account of translation reveals his effort to bridge the divergent interpretations of the contract and the guidance and legislation associated with that text – as well as his work to bridge the three policy spaces of national policy creation, local implementation and service delivery. There are strong images in Steven's account of providers being "split" by differences in information and individuals who are "stuck" as a result. Steven seems to have a sense of the ramifications of this work on more than a systems level; he sees the person at the centre of that care as well as the care home which provides their support. The sense of being "stuck" indicates to me a feeling of helplessness, and Steven's account lends a degree of empathy to that predicament. The activities he undertakes to translate guidance and legislation creates stabilisation by fixing, instance by instance, the meaning of these guidelines. He has to choose an interpretation and make it stick with the managers of care homes in his area as well as the people who access support.

SARAH AND MEETINGS

In discussing the role of boundary objects in organisation practice, Duguid and Brown (2002) suggest that knowledge is socially organised, involving the coordination of activities around an object that is known in common and generated within communities of practice. This viewpoint echoes Smith's (Smith 2005; Smith 1990a) contention that knowledge is embedded in social relations. I offer an insight into the value of communities of practice for contract managers in this discussion of Sarah and meetings.

Sarah attends a range of different meetings as part of her work. One of the most important is the "multi-agency quality assurance meeting" in which local authorities, the NHS, the Care Inspectorate and the police come together to discuss any serious incidents in the delivery of care to older people. In Sarah's account, these meetings can be quite "draining". There is often a large amount of information to get through and when the focus is on adult protection issues or poor performance in the care home, she seems to feel the emotional ramifications of that information:

Sarah: Every two months we sit down at the table in a multi-agency quality assurance meeting and that will have Care Inspectorate there, myself in contracts, planning commissioning, any adult protection officers and also have the reviewing team round the table, NHS come to that and if need be the police would be there as well if there is an adult protection issue requiring their presence – so that happens every two

months so the risk assessment work that we do indicates to us where our real issues are in terms of performance and quality. All that kind of drill down happens prior to the multi-agency meeting and then once we're round the table we've kinda of all got a good sense of where we're at with each home. But, it's a lot to get through in a two and half hour slot. There's a lot of information to take on board to share round the table. It's quite a draining meeting. For example, we just had one on Wednesday and the only items on the agenda were the care homes that were poorly performing.

Meetings involve a variety of stakeholders in the care sector: the Care Inspectorate, her colleagues in the council from planning and commissioning, the police, adult protection officers. In this case, the meeting is designed to share information across different parts of the care system. Here, the focus is on the performance of certain care homes or the resolution of particular adult protection issues. The network of people who are gathered to respond to these issues come from across the sector to support one another with understanding and resolving the issues that have been raised. It is "draining" work – a term I understand to mean that it is emotional work. Failing care homes and adult protection issues are fairly serious ramifications of poor quality care. What is more, Sarah needs to ensure that the information, the risk assessments and other paperwork, are in place before the meetings. The management of information does more than just the evidence the contract — it is necessary for managing critical incidents and crisis.

Sarah also attends another meeting in which mutual support and shared understanding are key features. Sarah sits on the National Reference Group for the NCHC, hosted by COSLA. In this group contract managers share the challenges of managing the NCHC.

Sarah: I attend monthly meetings at COSLA. We get round the table once a month and purely focus on the National Care Homes Contract and the issues around that contract — whether it be fee negotiations for the new financial year or sort of general issues that come up. It's quite unbelievable some of the things that they [the providers] come up with it – so it generally works well having that kind of shared experience in the room from the different local authorities. We all kind of have slightly different ways of interpreting things or managing parts of the contract so we generally come to the same conclusions about things and that's really useful to be able to share that. I take quite a lot of questions that have kind of built up over that month to that meeting. It's a really useful way to have shared experience and it's quite nice when you know that other people are facing similar problems and also to get a bit of help and advice and offer support and help and advice to others.

As Sarah suggests the NCHC reference group offers a way for contract managers to develop collective knowledge of the sector and support one another with some of the “unbelievable” problems they encounter. It is also a way to develop some shared support, and as Sarah says, the “shared experience” is really useful for her. In our conversation, she talked about the value of this group and the importance of sharing knowledge across the sector. For example, Sarah suggests that there is particular value in this shared knowledge when contract managers are dealing with chain operators – national providers who have care homes in a variety of local authorities in Scotland (and beyond). For Sarah, the problems that face local care homes may be a result of changes at an organisational level and that is knowledge that needs to be shared.

Sarah: Quite often we give each other a heads-up about areas of concern. Obviously we don't contract at a corporate level; we contract with the individual homes. But we do meet with the businesses themselves on a fairly regular occasion. If we're having an issue, which we do from time to time with a couple of the care homes in [our area] that are run by one particular national provider, we'll meet with them and discuss whether there are bigger issues that we need to be aware of in the organisation rather than in that particular care home. So that helps at a local level. But nationally we do need to kind of share that stuff and give heads-up to others. For example, we might learn that there is a management restructuring within an organisation which might feed down into the performance of the care home. So that needs to get shared.

The relationships within this community of practice carry on beyond the physical meeting space of their monthly interactions. They traverse the boundaries of local practice and support a collective understanding of the NCHC. Sarah uses her relationships with others in the contract manager community to support her work and help her resolve day-to-day problems when they come up. Since these meetings, and the relationships that are developed within them, have implications for Sarah's understanding and management of the care homes market. She draws upon the knowledge of others in her community to support her work. More importantly, she draws upon the support of the group to help her manage her day-to-day work with the contract. At times, she must deal with challenging issues such as adult protection issues or poor performance in care homes. These meetings have a “draining” impact. It is all the more important, then, that she draws resources from others. For Sarah, her meetings with other contract managers provide that support:

Sarah: I've been going to the group for the period I've been holding my post. Although some of the faces have changed, there's been about eight

or nine of us that have been there for the last couple of years and we often use each other over email and on the phone just to kinda bounce things off one another – you know, 'has this ever happened in your authority' and 'if it has, how have you managed it' kind of thing. There's one person who I think has worked with the contract since its inception and they have really, really good knowledge of the clauses. So if something comes up that I can't resolve, they're usually my go-to person and they are very helpful.

In their work to share information with one another, contract managers develop a shared meaning of the NCHC text. For example, their experience with different care home organisations is shared in an effort to support one another with the day-to-day work of contract management. The implications of this exchange is that contract managers have a shared knowledge of the different care home operators in Scotland: the problems they face, the tactics and “unbelievable” problems they raise. Shared support is more than just knowledge of the sector; it is also a shared approach to dealing with care homes in their area.

STABILISING THE NCHC: EMOTIONAL AND ETHICAL WORK

Contract managers work to interpret the context of care home activity. They make an effort to understand the challenges of recruiting and maintaining well-trained staff. They make a point of valuing consistency in the performance of a care home and raise alarm bells when there is a sudden change in their quality rating. Contract managers use their discretion to evaluate the performance of care homes – they meet with them and try to determine the support they might offer. But this work has its challenges. There are complex guidance and rules to be applied to the practice of care homes. These rules have implications for the price of care and the level of public financing available to individuals accessing support. And there are critical incidents within care homes which need to be discussed and addressed with concrete interventions from adult protection officers and the police.

Within this context, I have depicted the dual processes of stabilisation as, first, an activation of the text which requires the collection, management and interpretation of information. In this way contract managers stabilise the meaning of the NCHC within their work and the work of care homes. Fulfilling the information needs of NCHC is part of the day-to-day practice of contract managers and, in turn, the managers of local care homes

who have subscribed to the terms and conditions of the document. The second process of stabilisation involves the translation of the text into practice. Translation involves negotiation, discretion, “re-translation” and support. This translation work produces an ongoing relationship between care homes and the local authority. It also ensures that the meaning of the NCHC is manifest in these local contexts. This stabilisation is technical work. It involves measuring capacity, earmarking financing, and knowing how to manage contractual relationships, including assignation clauses and care home closures. It involves managing and documenting the home’s activities, including staff qualifications, resident care plans, inspection reports, and financial viability documentation. But without knowledge of the local context and a pragmatic, holistic kind of know-how, as well as knowledge of the other actors in the field and their roles and responsibilities, this kind of technical work would be rootless, without purchase.

This is also supportive work. It is not divorced from the rational-technical work of contract management; it is embedded within it. Contract managers understand risk in light of their knowledge of the care home and the issues at hand. They aim to ‘help’ care homes and always ‘have a discussion’ about their performance. Contract managers are not uniform in their approach; some are more flexible around risk and regulation than others, and some seek and provide support within their own community practice, while others seek to support care homes and people accessing support. This work to ‘support’ and ‘help’ is a kind of emotional labour: contract managers undertake a set of emotional efforts in relation to their work. But it is also more than just ‘caring about’ their work; their decisions are driven by a need to shore up the sector and they actively use their discretion to make ‘just’ decisions about their work. To echo Hochschild, this is sentient work (1983) – it is thinking and feeling work. It involves both emotional interpretation and rational judgment. The two are intertwined. Emotion, as I have depicted it here, is purposeful. Contract manager’s feeling work underpins their day-to-day management of the NCHC. As such, the emotional dynamics are rooted in the ways they seek to solve the information needs of the document, stabilise its meaning, and enrol care homes into the system.

Contract managers talked about the human, feeling, repercussions of their work – the critical incidents and the “tragic” events. They talked about the practice of supporting care homes – determining the problem behind the incident and finding out how to support them to improve. Their technical work is embedded in their knowledge of the sector as

much as it is embedded in their own ethics. They take seriously their “duty of care” and they support one another in meeting that duty. “Shared experiences” and the collective support to develop tools and share problems seems to be valued by contract managers. The need for this support reflects the “intensity” of their work and weight of the problems they may face. They may use technical solutions such as fee increases as quality incentives or meetings about staffing requirements, but the motivation for this seems to be rooted in their ethics to support the sector and the people who access support.

I depict this purposefulness as a type of ethical work. Contract managers are responsive and responsible to the perceived ‘needs’ of care homes. Their scope of authority to address some of those needs is limited – contract managers did not talk about their work in terms of its ability to shift the price/costs of care or to stabilise the number and retention of skilled staff in care homes. The scope of their discretion is limited — it extends only so far as the NCHC text and functions within a largely technical-bureaucratic domain. A contract manager’s domain is discretion over the interpretation of guidance or the application of a penalty. And yet within that sphere of influence, contract managers do bring a sense of ethics to their work. They deliberate over what to do and how to do it, they converse with one another and with care homes to understand the sector and judge accordingly. They do not “just do it” — there is careful thought, emotion and empathy here too.

DISCUSSION: ACTIVATING AND ENROLLING THE NCHC

In Chapter 4, I suggested that the NCHC was a response to a set of ‘information problems’ and that the artefact might be best understood as a boundary object designed to bridge these different needs and establish an ongoing relationship between actors who would otherwise be in conflict. I also suggested that looking at the national level of policy ‘creation’ is not enough; we must also look to the implementation of that policy in day-to-day practice. In response to the ‘information’ problems identified and seemingly ‘solved’ by the NCHC text, I explored the everyday contract management work of a small group of research participants and ask how they manage to enact those ‘solutions’ in practice. This work is framed as ‘text work’ and ‘relational work’ to capture the processes of activation and translation that they undertake to enliven the contract and meet its information

requirements and then translate those requirements into the complex world of care home practice.

This chapter sought to map the interconnections between the lived experience of small group of research participants and the system of care that they build through their day-to-day work and practice. These stories weave together their experiential accounts of the everyday knowledge practices of contract managers. They also map the significant relationships in the care system and give accounts of the translation work that is carried out to stabilise a set of relationships that make up the care system. These accounts are illuminated by the emotional dimensions of the interview conversation. While the stories provide a structure, a set of discernable 'facts' in the conversation, the emotional layers paint the picture and give substance and depth to these stories. But to what end?

In this chapter I have suggested that contract management work supports the production of the care system in the everyday. In this way the translation of knowledge in the NCHC boundary object does more than bring different sets of knowledge and practice together; it achieves the stabilisation of that knowledge and practice in both the local setting and then the sector as a whole. In relaying the narratives of small group of contract managers, I have shared a set of activities which have been previously invisible to researchers in the academy. We knew that contracts were used in developing and managing care home services, but the everyday practice of that work and its significance for the sector was previously unknown. However, there are also implications to this work. This translation has an impact on the sector – on care homes and on the everyday production of the system of care home support in Scotland. It is these implications that I draw attention to here.

Translation, as envisioned by Callon (1986), is the stabilisation of meaning and activity. It is the erosion of other avenues of action and the creation of one stable, agreed-upon, direction of travel. This is what contract managers achieve in their work. Their activation of the text through the collection of information is the first part of their stabilisation work. They enrol themselves and their local authorities in that work, as well as the care homes that are party to the NCHC text. The collection of information — verification of insurance, double-checking of grades, looking for risk — reflects a particular logic of the contract text and shows the particular ways in which contract managers spread that logic out to care homes in the sector.

The vision of the care home system that is being translated reflects, at least in part, the information needs of the document's framers and the particularities of the sector's problems as they were understood when the NCHC was created. This includes a need to stabilise the care system through a quid pro quo of quality incentives for stability and consistency of price. As I have interpreted it, that work to manage the "financing" is still a "large part" of their work. But it is also embedded in the everyday work contract managers do to make sense of the complex activities of a care home, the particularities of the different kinds of care provided, the different care homes and their individual approach to service provision.

In the previous chapter, I showed how the creators of the NCHC sought to make a standardised text that would bind all local authorities and care homes into one relationship. The value of the NCHC, in the language of ANT, lies in its ability to be "transported over a long distance and convey unchanging information" (Star & Griesemer 1989, p.411). Similarly, Smith's conceptualisation of the power lies in texts, though she is more explicit about the operations of power in that exchange. For Smith, the convergence of dominant ideas which coordinate and constrain people's activities from out with their locale is called "the ruling relations" and includes the mechanisms of the 'state', bureaucracy, formal organisation and so on (Smith 2001, p.161). IE practitioners are particularly interested in the way texts pull people into a dominant meaning and practice: "The text is the a material object that brings into actual contexts of reading a standardised form of words or images that can be and may be read/seen/heard in many other settings by many others at the same or other times" (1999: 7). This is reach of the NCHC text, but its stabilising power is enacted through practice. The contract is a one size fits all document until it is confronted with the realities of practice. It is here that care homes are actually 'enrolled' into the document. Signing up to the NCHC is just the first step in an ongoing relationship and process of regulation and negotiation. Grades are awarded and prices are raised or lowered. Individuals in need of residential support are admitted to care homes after an assessment by local government. Placement agreements are signed and a payment for care is made. There is very little about this document that is static. It is an ongoing tool for the management of the care in the sector.

This translation work draws down the meaning of the contract from the national level and enlivens it locally. Contract managers implement the NCHC across the multiple care

homes in their area. Care homes and Councils also use the NCHC to formulate the contractual relationship between resident and care home. In this drawing down, contract managers work to stabilise the care system vertically, by linking the work of national policy actors and local governments. In their enrolment of care homes into the NCHC, they work to spread the NCHC out from the local government and draw in, horizontally, the work of care homes in their area. Their translation work is multi-dimensional. Their work to support the sector is divided — as indeed they are — between the needs of the sector and the needs of the NCHC text.

Enrolling care homes into the NCHC fulfils the requirements of the national policy actors and the text itself which exists to bring care homes and local authorities into an ongoing, relationship. As this chapter has shown, there can be tensions between the NCHC and contract managers' perception of the needs of care homes. The NCHC text was designed to drive up quality through a penalty and reward system and yet contract managers described a more pressing need to ensure care homes remain financially viable (and therefore open for business). When contract managers work to support care homes, they often do it out with the contract's logic and designated framework of activity. Their 'help', particularly in terms of the incentive/penalty system, deviates from the clauses of the NCHC text.

The accounts of these four contract managers suggest that managing the NCHC is a challenging process, not just for the amount of information that is required to evidence the text, but for relationships which they must manage in order to hold it all together. Working with care homes is a discursive act – it involves conversation and negotiation. Meeting with care home managers, knowing about the consistency of grades, understanding the improvement in the sector over time, re-translating complicated guidance: each of these activities requires the contract manager to know their local context and the national policy context in which they are embedded. There are particularities to translation work of contract managers. As they describe it, risk is relational, determined by a subtle understanding of the differences in parts of the care home's operations. Regulations are also relational: they have a historical record and relate to each other as a mess of overlapping and contradicting guidance. The contract manager relates to these risks and regulations by trying to unpick them and re-translate them so that they have a coherent meaning. The interpretation of grades within the

context of care home activity, discretion on the use of penalties, the deciphering of CRAG rules on the public or private status of people accessing support, the coalescing of shared meaning between contract managers – each reflects the accomplishment of contract logic within the day-to-day realities of practice. This is the work of policy implementation.

In doing this work, contract managers apply their judgment, rooted in their understanding of the context and the needs of care homes. As translators, their work bridges the needs of the NCHC and the needs of the sector. In the accounts I have depicted here, I have suggested that this work is both rational-technical and emotional. I have also suggested that it has a purpose – that the work of contract managers are reflective of their ‘sentient work’ to make sense of their context and apply ethical as well as rationally technical judgments. On the one hand, contract managers talking about their approach to care homes in supportive terms. They have ‘discussions’ with care homes about poor grades and use their discretion in implementing a penalty. On the other hand, the work of contract managers aligns with the logic of the document that the NCHC is implemented and its core components (standardised pricing, ongoing relationships between care home and local governments, incentives for quality improvement) established in the sector. In order to do this work, contract managers talked about the support they provide one another and the need for a community of practice which ‘helps’ them to develop a ‘shared meaning’. Here the idea of ‘help’ is inward looking. In this case, help is formulated as an internal support to enact the contract, and is framed in oppositional terms – for instance, ‘it’s amazing some of the things they [care homes] will come up with’.

The dual sense of ‘help’ in this chapter reflects the dual purpose of the translation work that contract managers undertake, sometimes working to meet the NCHC’s needs and sometimes working to meet the needs of care homes in the sector. As will be reflected in the next chapter, these dual purposes can create conflict in the sector. Care home managers have their own views of the NCHC text and its implementation. I explore these perspectives in Chapter six, focusing on the ways in which care home managers resisted the NCHC.

INTRODUCTION

In the previous chapter I depicted the practices of contract managers as a process of activation and enrolment, which serves to translate the NCHC into the everyday work of local governments and their relationships with care homes. In this chapter, I explore care home managers' responses to that work. Together these two chapters show the implementation of policy into the practice of service delivery. In looking towards the experiences of care home managers, I attempt to carry the threads of the narrative, that begin with the creation and activation of the NCHC, through to its implications for care home services. In order to explore the experiences of the contract from the location of care home management, I examine their work in three forms. First, I look to care home managers' understanding of the NCHC document as an artefact, taking up the creative policy making process described in Chapter 4, and showing the perspective of the NCHC text from the users' viewpoint. Second, I examine care home managers resistance to the activation work described in Chapter 5, showing the work that they do to meet the requirements of the contract text and their resistance to its translation. Third, I analyse the relationships between local government and care homes and show care home managers' resistance to the enrolment of the NCHC.

This chapter draws upon the experience of five care home managers working within the framework of the NCHC document to provide residential care to older people in Scotland: Stanley, Martha, Tom, Joe and David. These managers work in different kinds of care homes and operate at different levels of their organisation. Some managed care homes which were part of small companies or charities, while others were regional managers or large-scale care home operators. The focus on the NCHC situates our conversation in a particular place. We talked about the contract and other documents or practices which inform the work of contracting. Our conversations did not often extend into the day-to-day work of care work. Most care home managers made reference to this work and to the work of managing their staff or speaking with family members, but the bulk of our

discussions centred around the nature of the national care homes contract and the field of care home regulation.

Care home managers talked about the work they need to do to meet the requirements of the NCHC. This work seems to be dominated by texts. There are multiple forms to be completed, letters to be mailed, conversations to be had about these documents, emails which follow up on the completed documents. In each case, the people who do the work of meeting the needs of the NCHC also do the work of meeting the needs of the staff and local residents in their care home. At times during these conversations, care home managers conflate the work of contract managers with the work of the Care Inspectorate. This is understandable given that both the local authority and the Care Inspectorate perform regulatory tasks around care home services. As will become clear, the Care Inspectorate grades were a significant feature of our conversations. As the national regulator of care services in Scotland, the Care Inspectorate are a dominant player in the sector. Their regulatory work is implicated in the NCHC as a part of the penalty/incentive system for care home quality.

Care home managers resist the activation and translation of the NCHC document — though importantly, few suggested that they would do away with this document as a stabilising device. In the following two sections, I unpick some of their resistance work — linking it back to the contract manager’s text work and relational work described in the previous chapter. I suggest that care homes’ resistance work is also textual, relational and emotional — that they respond in kind to the work being done ‘to them’ by contract managers. In exploring these resistance tactics, I draw out some of the reasons for this resistance work, and the links between the regulation of the NCHC and more wide-reaching problems in the sector around power, control and legitimacy.

TEXT WORK: RESISTING THE ARTEFACT OF THE NCHC

My conversations with care home managers began with a discussion of the National Care Homes Contract. We talked about the requirements of the NCHC, the changing landscape of the contract document (which was under review at the time of my fieldwork), and the meaning of the document for their work and provision of quality care to older people living in their care homes. Some of these conversations focused on the text itself — the

document and what it said — but the bulk of these conversations dealt with the meaning care home managers felt it contained for the sector. The NCHC is symbolic of more than the relationship it creates between the care home and the local authority — it reflects a set of systemic problems for care homes that go beyond the document itself.

STANLEY AND THE NCHC

Stanley is the manager of a small voluntary sector care home organisation. The charitable nature of the organisation influences the scope of Stanley's work. He is responsible for directly supervising the care managers who run the care homes as well as the business of managing the organisation — this includes marketing and finance, human resources management, regulation, contract management and so on. Stanley had concerns about the role of the contract. It prompted me to ask him whether he felt the contract was a worthwhile document:

CR: I guess the issue could either be that the content of the document is un-helpful, right, it's the wrong stuff, or it could just be the document in and of itself is the wrong way to go about this

Stanley: No, we need a document of this ilk. But the local authorities are using it as a means to exercise creative control of the private sector, and they would argue that they're doing it so we cannot have another Southern Cross, but actually it's more fundamental than that.

Stanley seems to separate the NCHC as a text from the implementation of that text by local governments. The idea that the NCHC was necessary but that its implementation is flawed was a common position amongst care home managers, as we will see throughout this section. It establishes an important distinction between the stabilising work of the document and the potentially de-stabilising work of local governments to use that document in practice. It's a distinction that I take up in this thesis and forms part of the rationale for articulating this policy process in three separate stages: creation, implementation and resistance.

The issue of "control" was a common feature of my conversations with care home managers. To me, it reflects their central concern with the implementation process — that it is a tool for controlling the care home in order to prevent failures like Southern Cross. In

this passage, Stanley talks about “creative control” — a term I understand to mean the overarching control of one party over the outputs of a process.

MARTHA AND THE NCHC

Martha is the manager of a small, voluntary sector care home. She has experience in local government and knowledge of the processes of contract monitoring from the perspectives of both the local authority and the private sector. Like Stanley, she questions the meaning of the contract document for the sector, suggesting that the principal driver for the document is a desire to create uniformity in the provision of care for older people. Martha suggests that this rationale is undermined by the practical realities of 32 local authorities which means there are 32 different care markets, 32 different local strategies for social care and 32 different sets of local politics.

Martha: We say that we've got a national contract for Scotland and it is the first of its kind, and the whole thought process behind it was good, the whole concept was to try and bring some uniformity and to bring fairness and transparency but you've got thirty-two local authorities with thirty-two different work forces, and care homes with different amounts of beds and standards — everything's different.

It seems that the value of “uniformity” and “standardisation” are both useful to Martha, but the breadth of work it needs to cover and the range of local needs and contexts is also a risk. Like Stanley, there is a sense in this passage that that the purpose and articulation of the text are “good” — but something is lacking in the manifestation of the text. I asked Martha if there were particular parts of the contract which she found useful for her work. She talked about three particular areas: the tenancy agreement, the national standard for pricing, and the minimum staffing requirements — each of these mechanisms was named as a stabilising device by the document's authors (see Chapter 4).

Martha: The good things that came out of the contract, I'm not saying they work, but for me a good thing is the residency agreement. The residency agreement is the agreement between the provider and the resident — it's the only bit of paper that the resident would have — it's like my lease agreement if I'm gonna rent a flat from you, or y'know, this is what I'm getting for my money. I think that that was a good thing. I think there could have been a little bit more consultative work on it, but, if it's not monitored, and the council don't know who has done it — what's the point of having it, but I think that's a good thing.

At the root of Martha's concerns is her sense that no one is monitoring the document. For Martha, this lack of capacity undermines the process of regulation.

Martha: There's nobody set up to do contract monitoring, if I put a contract in place and I know nobody's monitoring it, why would I adhere to it? So, every provider knows, as do the council — here's your contract and what they will do is if my percentage of staffing falls and they've got an opportunity to take money off me they will, but there are more occasions that the council are in breach of the contract than we as providers are, so what is the point?!

For Martha, there is a lack of trust in the process of regulation. She questions the council's capacity to regulate. But she also questions their motivation. These questions arise from her sense that local governments will use the contract to achieve their own financial gain. Underscoring this account of inconsistency and control, is Martha's sense of frustration with the council. As Martha suggests, 'what's the point' of working with the council and the NCHC when there are different practices depending on 'who' is in breach.

Martha: But that's what the council use to argue their points if they need to claw money back because it's all about money for the council, so they use the contract when it suits.

The NCHC document is unstable. The meaning for providers like Martha is unclear. Is this a regulatory tool? If so, why are the activities of regulation so invisible? Why does Martha feel that there is no regulation around the tenancy agreement? Her answer to this question, at least in the context of our conversation, is that councils use regulation to suit their own financial needs. While Martha might approve of the rationale within the contract, her experience of the activities of managing the NCHC undermine the positive aspects of the document itself.

TOM AND THE NCHC

Tom is a managing director at a large care home company which I've anonymised and called Stillwater Care. Stillwater has care homes across the UK. As managing director, Tom manages two large geographic areas in Scotland and England. He has regional managers for each area who oversee the care homes in their jurisdiction. Tom's view of the sector is informed by his background as a nurse and his years as a regional manager for Stillwater. As a managing director, his vantage point is both strategic and local. We talked about national policy debates, differences in the Scottish and English social care systems

as well as issues facing local care homes in the area. One of the benefits of the NCHC for Tom is the ability to negotiate a standard fee.

Tom: To be able to set and negotiate a National Care Home Contract fee across all the local authorities is absolutely brilliant. Just now in the northeast of England we're negotiating separate rates for every council, and if you add to that the local NHS, y'know, and the move towards joint contracting, it's very difficult and very complicated. There's no ability to look at any volume reduction, for example — whereas we could do that in Scotland. It makes it far easier. There's not one provider reducing rates to fill the beds — if that was the case, I'm sure that some providers would go out of market.

In highlighting the value of the single standard fee-rate for publically funded care homes residents across Scotland, Tom echoes the perspectives of the NCHC creators as presented in Chapter 4. There is a sense that NCHC has dulled the harsh edges of the market in the Scotland. From Tom's strategic vantage point, the work of managing care homes in Scotland is vastly different than the separate rate and negotiations which his organisation undertakes in England. This is not just a bureaucratic difference — the standard rate for care home placements ensures that care home organisations can manage the volume of care home beds/institutions. It also means that there is less drive to the bargain basement of social care pricing — a practice which has impacts on quality of care and, as Tom suggests, the stability of care homes in the system.

JOE AND THE NCHC

Joe is the owner and manager of a small care home company and a regional representative for Scottish Care, the representative body for independent sector care homes in Scotland. In our conversation, Joe suggested that his care home work was informed by a long history in public service. Joe echoes Tom's statement about the importance of a national fee rate. For Joe, the negotiation of a central fee rate has given the providers a voice within the national debates about the cost and quality of care.

Joe: I think it give us a solid base, we've been able to maintain a concerted national pressure group which basically meant that whilst they kept trying to raise quality, we've maintained a price. In other areas, they've reduced prices. In areas that aren't covered by a national contract down south, councils have actually lowered the cost, and you'll see from, your research I am sure in England care home groups have taken county councils to judicial reviews on the fact that they are not paying a fair price

for care and have won, alright. Now we didn't get pushed into that, we've argued a point, and argued it for a long time.

While Tom describes the value of the NCHC to the market, to the planning of the market and to the viability of providers within that market, Joe shows the implications of that price for users of the system.

Joe: At the beginning of the National Care Home Contract they went away to look at the true cost of care. We all know that they are still not meeting the true cost of care. For example, in one of my residential homes we'll charge £900 a week, alright, for a single room whereas the actual rate in the NCHC is under £500 for that room. That's the difference.

Care home managers find value in the NCHC, though much of this is tempered by their feelings about the activities which surround it. Some care home managers, like Tom and Joe, agree that the document gives them a national platform to engage in policy and planning. Others, like Martha, suggest that the focus on transparency has been useful. She highlights the tenancy agreement as one of the ways that transparency is promoted, in this case around the provider and service user. Care home managers were quick to point out the weaknesses in the regulation by the Care Inspectorate and council, particularly the capacity for regulation and dual regulation. There were strong suggestions that the council will use the regulatory tool of the contract to their own financial gain. To me this concern suggests there is lack of trust in the relationship.

TEXT WORK: RESISTING THE ACTIVATION OF THE NCHC

Care home managers resist the textual work of activation. The careful work that contract managers do to create tools and manage complex information is refuted within the sector. Care home managers question contract managers' knowledge of day-to-day delivery of care and the use of the grading system to improve quality. These accounts here also indicate their perspective on the repercussions of this activation work for people accessing support.

STANLEY AND LEGITIMACY

Stanley raised a series of concerns about the local authority's legitimacy. He talked about the distance between contract management and day-to-day activities of care. In Stanley's eyes, their lack of hands-on care knowledge de-legitimises their monitoring activities.

Stanley: My instinct says that we need to tick pages to prove that we're doing what we're doing. I think it's basically is a recipe for them [contract managers] to come in at will, and that's not helpful, and therefore that's a distraction. In order to make sure that they're satisfied — that the guy that sits at his desk all day and doesn't really do anything for care, but monitors people who do — monitoring uh using the word lightly. He finds reasons to make you work so that our care managers are spending far too much time making sure that we've got bundles of papers on x, z, and y.

Stanley seems to imply a tension between the “desk” work of contract management and the frontline work of care that he and his team undertake in the care home. In Stanley's account, this work seems to lack purpose — it's about making sure “bundles of paper” are in place rather than ensuring that the care is recognised and valued. When we talked about Stanley's experience of grades, he indicated that his care homes tend to be ranked quite highly. There is a waiting list for each of the care homes which he manages and he told me that he repeatedly hears positive affirmations from residents and their families. Despite this relatively positive position within the regulatory system and experience of delivering care, Stanley's expressed numerous concerns about the administration of the grading system by the Care Inspectorate.

The blurring of boundaries between local government monitoring, as described by Stanley above, and Care Inspectorate regulation described here. This was common throughout our conversation, and echoed by other care home managers in this chapter. As I understand it, the regulation of care homes is experienced as an ambiguous mix of local government and the Care Inspectorate. At the fulcrum of both kinds of regulatory attention, is Stanley and care home managers like him:

Stanley: Our Care inspector wears as a badge of pride the fact that she has never given a six, and never intends to give a six. So there you are, you're immediately back at school, well when I was younger at school you never got any more than seventy-five for an English exam, so it's that kind of thing, sixes are never, and ones are very rare so you're really talking about a range of two to-five. Other inspectors are much more willing to give full marks.

Stanley experiences regulation through the assessment of an individual regulator who is responsible for the particular geographic region where his care homes are based. He articulates a sense of unfairness in his description. The grades themselves are not the

issue here as much as they way they are understood and applied by the care inspector. Stanley's criticism of regulation extends beyond the discretion of the individual inspectors. He questions the system itself when he wonders whether its possible to capture the quality of care using the current tools available to regulators.

Stanley: The fundamental problem with care inspections, and that's not a criticism of individuals involved, it's the regime — it's the system. There's probably no other better way of doing it, but it's a paper exercise, it's a box ticking exercise, and, some inspectors and our own is like that, comes in, and looks for things that are purely second order indicators of care. They'll talk about getting a feel and a sense of how care staff are working with residents it's the first thing you say to someone who's looking around for a care home for their loved one — there are questions to ask but ultimately it's what you pick out of the atmosphere: are residents happy, contented, alert, to the extent they can be, do you feel that there in a part of the family where they're accepted even if they're making noises? Are the care staff seemingly, enjoying what they're doing? That's the kind of thing you can't quantify, you can't actually describe it very easily. I don't envy care inspectors trying to get that out in a score, you can't score it.

Stanley resists the “paper exercise” of using grades to determine quality, suggesting that the experience of care can't be quantified in a “tick-box” exercise. As Stanley suggests, the approach of the regulators has taken him back to school — a phrase I understand to mean that he feels disempowered by the arbitrary administration of the “system”. Though he's careful to suggest that it's not the inspectors themselves that are the issue — it's the use of these ‘second order indicators’ to understand the complexity of care. In Stanley's account, one of the central stabilising mechanisms of the contract — the use grades to evidence quality of care is called into question. Not only does this mechanism fail to stabilise care — it may even be a “distraction” from the delivery of care. Stanley makes a clear delineation between the people who provide care (care homes) and the people who “don't really do anything for care” (i.e. local authorities). This divide is at the heart of many of the accounts I present here. From a care home's perspective, monitoring is not “helpful” — it doesn't do anything to support the care they provide.

MARTHA AND “REPRECUSSIONS”

Martha describes some of the downloading that can occur within the regulatory regime. When care homes are sanctioned for poor grades, their resources to repair and revive the

care home are hampered. The resident of the care home feels the impact of this, in Martha's view, most acutely.

Martha: The next thing I have a problem with is the gradings. The fact that, if you fell below a certain grade, then there was a discussion with the local authority. What I'm not a fan of is them taking money off you. If they take money off us, the only person that suffers is the resident. If I lose my grades because I've not got enough equipment or I've not trained my staff properly or the standards aren't good, the only thing I've got to inject into that business is money. If you then take money off me, because I've not done it, the only person that suffers is the resident because what you'll find is people will reduce the budget for food, they'll put one less on the night shift, that's ok, 'til there's a fire, that's ok 'til something happens and there's nobody monitoring it.

For Martha, the use of the penalty and incentive system has very real impacts on the people who access support. She refutes the stabilising device of the quality incentives/penalties by suggesting the reduction of the fee rate will only harm the business itself. She is very candid in the implication of this and suggests the inevitable consequences are a reduction in the budget for food or staff.

TOM AND TECHNICAL KNOWLEDGE

Tom describes the discrepancy in knowledge between care homes and the Care Inspectorate. As national regulators, the Care Inspectorate are tasked with certifying care homes and allowing them to enter the care market. After the Southern Cross failure, Audit Scotland suggested that their evaluation should include the financial dimensions of the organisation (Audit Scotland 2012). I asked Tom if the Care Inspectorate understood the technical aspects of his job as a way of exploring the knowledge resources in the sector and the ability of the care regulator and local authority to prevent another large scale care home failure.

Tom: They don't understand. To be fair to them though I think the way the care home sector, for the bigger ones like us, has developed — it's acquired and acquired and acquired and so you get a lot of holding companies. In the past I think it was hard for them to understand because if Scotland's got sixty homes they are not under one company, ultimately they are but they could come under a separate company that developed as an acquisition in the past, not for tax evasion or anything but because of the way we're structured. So, if they went into the company by company accounts, it wouldn't mean anything because it's the other overall aggregate position which is the important one.

Tom account indicates a knowledge gap — which chimes with some of the work that contract managers described in terms of their ability to capture financial indicators of risk. Activating the NCHC text without the knowledge or expertise to manage financial information has its limits. Tom draws attention to different ‘worlds’ of care home management and regulation. Care home managers are experts in their field of practice and the management of their home within the market for social care, including the financial operations of their homes and their obligations to local governments, their staff and suppliers, and the residents of their homes. In this account, Tom highlights that disparity by listing some of the technical details about the structure of care homes and the lack of commercial knowledge within the Care Inspectorate. This disparity underscores some of the claims of illegitimacy raised by other care home managers.

JOE AND CAPACITY

Joe has similar feelings about the knowledge and experience of contract managers. He vehemently resists the scope of contract management, suggesting the local governments lack the expertise to appropriately understand the care being provided. This echoes Stanley’s claim that contract managers and their “desk work” are ill-suited to understanding the complexities of care. Likewise, Tom’s account of the Care Inspectorate’s lack of knowledge on the commercial operations of care homes also chimes with this resistance. Like Joe, care home managers repeatedly voiced their discontent with the knowledge base of the monitors and regulators.

Joe: If someone came in — I will, I will, I will oppose it. I said to [the contract manager] don’t you come to my home. If you step through my door I’m gonna eat you alive. That’s just not going to happen, I will go to court over this, alright. Contract monitoring doesn’t require you to look at somebody’s care plan, you have no knowledge and expertise to do it, y’know, to look at a room, to look at somebody’s health. I am not going to allow you to come in here!

Joe was quite expressive in his resistance of contract monitoring. He suggests a physical resistance much more than Stanley or Martha have done. In light of Martha’s suggestion that it is the residents of care homes who suffer from the stabilisation mechanisms — Joe’s anger at a contract manager’s intervention is to suggest that they have no knowledge of the services that are provided — have no expertise to understand a care plan. For Joe, this warrants an outright refusal to allow that contract manager to monitor the residents, or

involve themselves in supporting care homes the way they described in Chapter 5. Moreover, when Joe spoke about his resistance he spoke with a visceral quality. Joe's description gave me an image of a blocked door — a physical rebuke — and it was vociferous.

For Joe, it seems the strength of his reaction stems from his view that the council has failed to provide to support to the care system itself. He is specific in his fears that the lack of support for the Disclosure scheme can result in a failure to meet the specified terms and conditions of the contract. Failure to meet the terms and conditions can result in a reduction of the default payment for local authority funded residents.

Joe: I think that, umm, that an example of that is the PVG [Protecting Vulnerable Groups] scheme, right — from the point of view that, here they are they set this system up by the Scottish Government being enforced by the Care Inspectorate, which basically is stopping you operating social care, so all of a sudden, no one is gonna get PVG's, all of a sudden you haven't got people to work in social care and it collapses right at the coal face, standards that they haven't put a structure in, to actually, handle that work — And umm, what, what happened on that, on the PVG side was some some care homes were so close to the level on staffing figures, that they were having complaints put in, taking more time for the inspector to inspect that complaint, upholding that complaint, that the actual providers were saying, what can I do? I've got all these people for interview, I've been trying to start them, and you won't let me start them, then the council saying, because you're falling down on there, we are going to take money away from you and we may even stop anybody coming into your home, and all of a sudden you're seeing, based on this weakness in your system, we are jeopardizing the fact that we are not going to be able to give care.

Joe and Tom's resistance point to a lack of knowledge in the approach of contract monitors and regulators to the sector. This is echoed by the sense of misdirection which Stanley and Joe allude to — the suggestion that the activities of contract monitoring are a hindrance to the actual provision of care. This is emphasised by Martha who candidly claims that the repercussions on the sector will only impact the people who access support. Care home managers talked openly to me about the strain that regulation creates. Like Joe's account above, some of this regulation is strongly resisted. Others, like Stanley, simply point to the inadequacies in the system. But in each account, the work that contract managers do to collect information and evidence the requirements of the contract is resisted. Importantly, this resistance is not specific to individual contract managers or even their evidence gathering work — it a resistance to the contract document and the

logic of its stabilising tactics. The grades and penalty/incentives systems are refuted — as is the knowledge of the contract monitors and their careful efforts to support the sector through discretion and interpretation.

Sometimes this was a question of fairness. Care home managers had questions and anxieties about the way that regulation is carried out. There were also questions about capacity. Care home managers seem find regulation to be inconsistent. This delegitimises the process of regulation for them. They questioned the council's role in regulation versus the role of the Care Inspectorate. They questioned the capacity of councils to regulate. They also questioned the Care Inspectorate's technical knowledge of care home management. The issues they raised around legitimacy reflect their concerns with power. Care home managers asked fundamental questions about the local authority's authority to regulate their care homes. They also asked questions about the fairness of the power that is exercised. Some of the stories they told me reflect their own activities of resistance.

RELATIONAL WORK: RESISTING THE TRANSLATION OF THE NCHC

Care home managers' accounts of working with local government to enact the NCHC suggests that their experience is full of conflict. Local authorities are depicted as arrogant, lacking in local knowledge, self-interested competitors and bullies. The one exception to this narrative, David, suggests that care homes are just an extension of local government, subsumed within the logic of the local authority. I unpick this narrative of conflict and enrollment to show the implications of the translation in practice.

JOE AND BUREAUCRACY

Joe brings a degree of suspicion to his dealings with the council. He spoke about the council as a 'machine' — a "faceless" and "petty bureaucracy".

Joe: One of the biggest concerns that I have in all of this, is you're dealing with, an almost faceless [system]. You're dealing with people who have preconceived ideas. What appalled me more than anything was the whole attitude towards private care homes — it's a nasty word — you're making profit out of our elderly, that was the view. Now, that wasn't our choice. That was a government choice to split health and social care in the way that they did and to fund it in the way that they did. Funding of

social care has always been grudgingly given, right. One of my biggest concerns in the role that I play is the demonisation of the care sector workers and care homes in general.

For Joe, this facelessness leads to arrogance. In his account, these ‘faceless’ bureaucrats don’t see the real issues around providing care — they don’t know the work that care homes do and as a result they mismanage the regulation and they overreact.

Joe: There are providers out there who sign up without looking at the detail. They say ‘I haven’t got this and I haven’t got that, but it’s okay no one is going to look at it’. But when [the council] come in and they do look at it, they will undermine you to such a degree that you could lose your business, alright, so that’s a point when I have a problem with it. They are setting us up for a fall, alright, because of their arrogance.

Joe’s account refutes the interpretive work and local knowledge that contract managers depicted. In contrast, local government is said to be ‘arrogant’ and ‘petty’ — terms I understand to suggest that care home managers feel there is a narrowness of their approach — one which does little to take account of local circumstances or understand the complexity of the care being provided.

STANLEY AND ‘CARTE BLANCHE’ CONTROL

Stanley has concerns about the extent of the councils’ control over the operations in his care home. In his opinion, the use of the NCHC to monitor all of his care home’s activities is a step too far. He suggests that there should be division of monitoring between those people who receive public support for their care and those who are privately funded residents.

Stanley: It [the NCHC] gives local authorities carte blanche to come in as and when they want. Now my simplistic rationale is: local authorities are responsible for local authority funded residents. They would argue they are responsible for every resident whether they’re self-funding or not, but self-funding resident receive government funding for free personal nursing care. The local authorities are simply a channel for that. It’s local authority budgets that fund, social work funded people, it’s government money that funds self-funding people with free personal nursing care. The Care Inspectorate is the government’s arm to inspect and regulate the care sector, so first of all before we even get to the whole thing of dual regulation, which I think is where this contract’s going, we need to have separation that says, well you want to come in and look, you can only look at the ones that you’re funding — the ones that you’re responsible for, because that’s what the National Care Home Contract is meant to apply

to.

Stanley questions the extent to which local governments should be able to regulate their activities. He sees the NCHC (particularly the draft that was under review at the time of this conversation) as an attempt to extend local government control of the care home sector. The driver for this extension, in Stanley's terms, is financial.

Stanley: There is a triangular relationship — we've got providers, the Care Inspectorate and local authorities managing the contract and trying to kind of come in and basically push the Care Inspectorate away. They just want to have the overall thing because it's a huge budget issue — it costs a lot of money.

Stanley's suggestion that finances are the real driver behind the council's contract management strategies derives in part from the competition between private sector providers and local authority care homes.

Stanley: The thing that really irks that — you'll have heard of long before but I'll just say it for the record — is the fact that we get £550 for a nursing care place per week, offset of course by our own income contribution, and the local authorities go, 'oh no we can't afford any more than that at all, and why aren't you producing the same quality care as we do in our local care homes', and that's because under freedom of information you find how much it costs to run a local authority care home, £950/week, per resident.

The fact that local governments are direct competitors with providers creates a tension between the two parties. In addition, the discrepancy between the cost of care in local authority homes and the local government payment for care in private sector care homes undermines the local government's efforts to regulate the care sector. Stanley suggest that contract monitoring goes too far — that it includes areas of his practice far beyond the local authority's purview. He depicts local government as power hungry — keen to push the Care Inspectorate out as the national care regulator and use their own authority to keep track of the quality of care in the sector. His concerns are further complicated by his view of local authorities as direct competitors for people accessing support. Here he suggests that there is a double standard in the sector and questions their legitimacy to regulate his care homes.

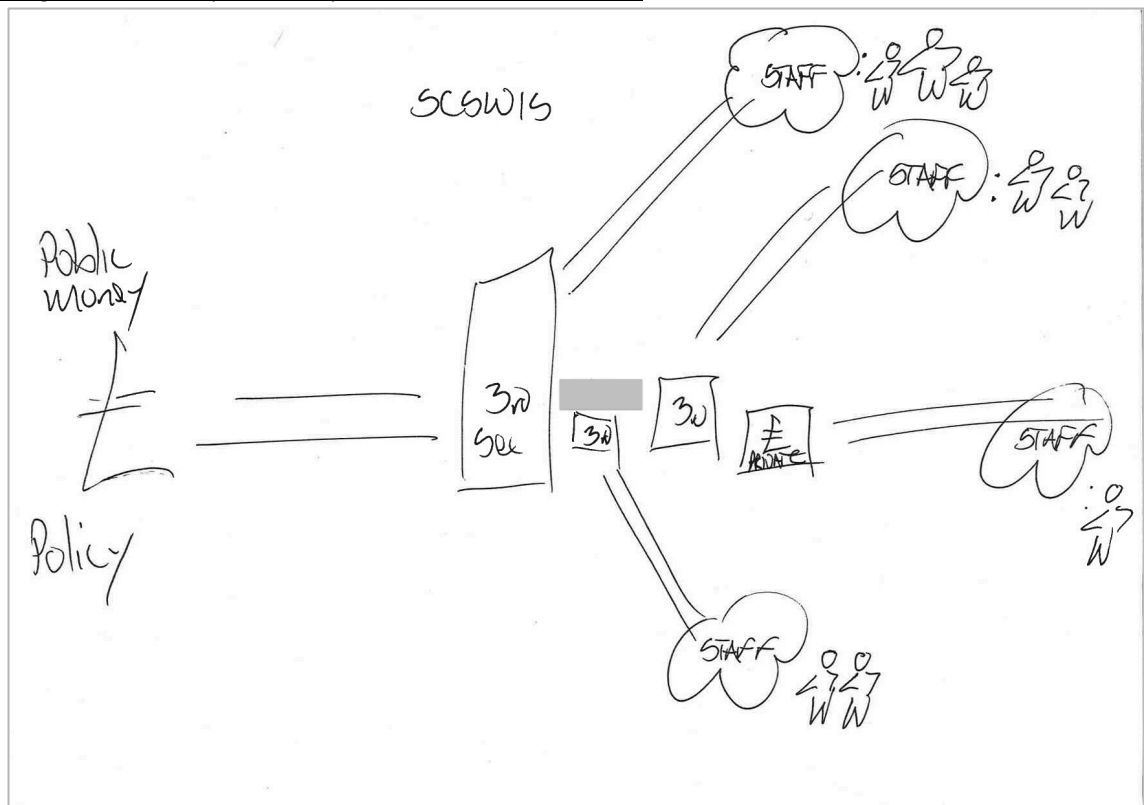
DAVID AND DEPENDENCY ON THE LOCAL AUTHORITY

David's account of his organisation's relationship with local governments runs counter to the one provided by the other care home managers I spoke with. His view is that care homes act as a conduit for public money, channelling that resource to staff who provide the service.

David: We're the labour market if you like, I suppose the thing about purchasing and commissioning is Oak Left simply act on behalf of the local authority as a conduit. We give money to staff, so you could think of us as an administrative function. We're just a little bureaucratic offshoot of local authorities. We're just a pipe. All we do is process their cash in a particular way to give to our staff.

This perspective came out in the mapping exercise that I asked David to do. In this map, David has articulated the local authority on the left-hand side with the '£' sign, placed his organisation in the middle and made a set of satellites of staff and residents.

Diagram 4: Participant's Map of the Social Care Sector



While some care home managers resist the local authority, at other times, the perspective of the local government is absorbed into their practice. This may suggest a difference in the reliance on publicly funded residents. In areas of greater affluence, the number of self-funders (people with savings above £25,000) is likely to be high. There are number of areas in Scotland, where there is a mix of people using state support for their care and a number of localities where state support is dominant. The difference in provider perceptions of power could depend on the number of publicly funded residents who live in their care homes. Power differences might also have to do with the organisation's experience with the local authority. As I discuss in the following section, Oak Leaf's services were recently 're-tendered'. As a result Oak Leaf has dramatically changed their model of care. This re-tendering may have shifted the relationship between the organisation and the local authority so that Oak Leaf views itself as a funnel of local government resources and policy.

It also suggests that some of the work that contract managers do to translate the document into practice is more easily received - perhaps even too easily received. There are power dynamics at work here and interdependencies between local government and their financing of care home residents. Where care homes are more dependent on local government, there may be a greater need to adopt the logic of the contract rather than resist and manage the conflict depicted by others in the sector. The differences between David and the Stanley, Martha and Joe is explored further in the following section in which I suggest that care home managers take the individual identities of their businesses seriously and use the narratives of their reputation and formation as a organisation to refute the enrolment by local government.

STANLEY AND BREACH

The battles that care home managers discussed above have an emotional weight to them. There were very real moments of anger in these interviews. I have drawn attention to some of the emotional resonance in the accounts above. In the last vignettes in this section, I focus more explicitly on those emotional resonances. Stanley's anxiety about 'creative control' is rooted in aspects of the contract document itself. For example, the contract stipulates that the weekly fee can be reduced if the care home receives a low grade in their most recent inspection from the care regulator. Stanley goes on to detail his

concern that the local authority will reduce payment for publicly funded residents to subsidise its own budgets in light of the recent increase to their care home costs.

Stanley: It's as if they want to control the contract and have a means of controlling budgets so that they'll give on the one hand and say, well we can afford a two point seven five percent increase this year and the guideline rate, well great, it was closer than last year so thanks for small mercies but we'll take it back because we can find in clause fifty-seven B, Paragraph C, Section D you haven't actually managed to fulfill every single item, so, uh, you're in material breach and therefore for a period of three months we're taking twenty pounds off of your weekly fees for residents x, y, and z.

Stanley's anxiety seems to be about control. If the local authority exercises more control, they will encroach on the activities of his work, his staff and the residents of the homes he runs. For Stanley, this anxiety is expressed in technical detail. He talks specifically about price increases, contract clauses and budgets. He uses terms like 'material breach' which signal a break in the agreement between the local authority and the care home. The reduction of the fee rate feels like an unjust punishment when Stanley frames it in these terms. His view is that the local authority will invent a reason to find fault with the home and reduce their fees.

Stanley's concerns for legitimacy are also fraught with emotion. He worries about the 'clipboard' mindset that contract managers might bring to their work. He seems to fear for the implications of their regulation. Failing to meet the contract manager's criteria is a failure to meet the obligations of the contract document itself. This would be termed a 'material breach' of contract and its implications for the funding that care homes receive for publicly funded service users.

Stanley: Someone of the mindset, clipboard mindset and y'know there are many of them out there who go, well they've done that, they've done that, that one doesn't reflect that, well now it doesn't reflect this either, oh right ok, the others are fine, well you've missed that and that so therefore you are according to this clause down here in material breach of contract! Material breach of contract, significant!

The concerns for regulation have implications for care home manager's day-to-day work. For example, Stanley framed his day-to-day work in terms of protection and support. His job is to carry the weight of the organisational work so that the care managers can do the work of care-giving.

Stanley: Well, my role I'd see largely as, supporting them, and that's partly by taking the brunt of all this other stuff that if they worked in company X they would be required to do. So we have 115 FTE staff. Only three of those are not focused on care. So it's me and a couple of part timers and another full timer handling finance, umm, marketing, IT, HR, you name it, all the other things of which there are probably six or seven, fabric issues, buying, purchasing, all this kind of stuff, which makes life kind of frustrating for me, but that's all we can afford. But my task, my main task is when a care manager says look we've got an issue with this, is to say yep, I'm carrying the main burden of that — so that they are not getting caught up with and led by issues that will be a distraction.

In this chapter, I have depicted the work that care home managers do to meet the requirements of the NCHC text. In this account, I have shown aspects of this relationship which are fraught with conflict. These conversations were particularly challenging for me as a researcher. I had trouble unpicking whether the participants were upset with me in particular — or with the system in which they are embedded. In analysing these conversations, I have come to conceptualise the emotional dynamics of these interviews as a form of resistance. Care home managers weren't annoyed with me. But in asking about the NCHC, their feelings of anger and frustration, of hurt, became part of our discussion. These emotions are responses to the sense of control which care home managers described. Their concerns with the implementation of the NCHC and distrust of local governments and the care regulator were reflected in an undercurrent of 'push back' — a kind of resistance which seeks to block the dominance of the logic of the NCHC text and encroachment of local government into their practice. This kind of resistance is generative, in the sense that it creates space for care homes to maintain a sense of their own activity. It resists the enrolment of care homes into the entities that exist primarily to meet information needs of the NCHC. This generative work is also evident in the 'narrative work' of care home managers who work to create and maintain a reputation which is meaningful to residents, staff and their local community. This is the resistance work which I explore more fully in the final section.

TOM AND LOCAL AUTHORITY BULLIES

From Tom's vantage point, his relationship with the local authority is relatively route. His work with them involves a review process where local authority contract managers or care managers review the operations of the care home. This is one-directional. Care

homes might be required to show certain kinds of documentation, but the process is led by local government. Conversely, there are joint meetings and multi-agency working groups which are co-created policy spaces where local governments, providers, the NHS and other stakeholders work through 'issues' together.

Tom: The Local Authority [contracts teams] will do contract reviews. Care Management will do frequent reviews with the residents for the service. If there's any issues, if we did get a grade 2 then maybe we'd have some contract management meetings which would involve [my junior] and myself. We'd be in dialogue as well by email as well. If there are peculiar issues in a specific area for example, two or three homes having the same dilemma, it would escalate to me. We've done that as well, if there's a serious issue, the home round the corner for example, that became a multi-agency intervention.

These engagements are not always without incident. Tom's more neutral rendering of the contract and his relationship with the council is tempered by his discussion of power.

Tom: I think the National Care Home Contract is a definite positive for Scotland and it will continue to be, providing council's play ball and don't act as bullies

CR: Is that your sense of things — that in the past they've behaved a bit like bullies?

Tom: When they do the quality grading you can get from a one to a six. If you get a two in the first theme, which is quality of care, you can get downgraded. But that downgrading is only meant to be after a discussion takes place, and if you have an action plan which is robust, it shouldn't be downgraded. But very often the first port of call is to send the letter to say, you've got a quality rating of a two, we're going to take the quality payment off you.

For Tom, dialogue seems to be highly valued. Without it, he views the council as bullies. This account suggests that some of the supportive work that contract managers do to share knowledge and create harmonised approaches to shared problems in the sector might be interpreted as a united front — a coalesced whole which bullies the care home sector to fit local government needs and expectations.

RESISTING THROUGH NARRATIVE WORK

Care homes have histories. While these can rarely be 'read', they can often be told. There are those who can access those histories — who see and hear the cumulative and collective story of the care in that space. Sometimes those people are the managers, who

bring with them a responsibility to protect and promote that history. A manager's vantage point allows them to collect stories from across the field of activities in their care home and retell a version of that story. The care home managers I spoke with distilled these stories down in a variety of ways. They talked about the values of their care home or of care itself. Sometimes this was framed in the recruitment exercises they undertook or the way they managed their staff. In other cases it was told through a linear history of the care home — its journey through time and its shifting configurations along the way. In each case, managers described the local embedded nature of care homes and their importance to a local community.

Care homes managers use different strategies to carve out a voice for themselves in the context of the monitoring and regulation. They sit on local and national lobby groups. They attend meetings at the local authority to ensure that their voice is heard by local policy makers and practitioners. They work on developing and maintaining a reputation. They negotiate with local authorities and the Care Inspectorate. They explain their work and argue their case if they have to. They also develop a narrative about who they are and what their work means for older people in Scotland. I think of this as 'reputation work'. Their place in the sector and in the communities across Scotland and the UK is very important to care home managers. In the following section, I outline some of this narrative reputation work.

TOM AND REPUTATION WORK

As a managing director at Stillwater Care, Tom's vantage point is both strategic and local. We talked about national policy debates, differences in the Scottish and English social care systems as well as issues facing local care homes in the area. Tom talked frequently about the importance of reputation. Tom does work to maintain or build-up the reputation of his care home company. He sets this work against a dominant narrative of for-profit care home operators.

Tom: I attend some of the relatives meetings where there's been issues just to reassure them that the company takes this seriously so they don't think, again it's that perception about private companies I'm sure they still think we're money grabbing and making a big buck, in reality it's a hard buck that you make, certainly in Scotland because of the real cost of care and the real cost of capital it's not a big margin in this business for the amount of risks you put together.

Tom negotiates the perceived narrative of private sector care homes — the idea that they are more focused on profit than care. He also makes an effort to destabilise this narrative with his own care and reassurance. In this way his narrative work is two fold — a negotiation of a dominant story and a resistance or destabilisation of that story through caring work. Like Tom's meetings with relatives, his meetings with the Care Inspectorate are an opportunity for a similar kind of narrative work.

Tom: There's been a few issues [with some of our new acquisitions] so I will know why, and what we're doing to fix it, whether or not we need more resources to go in, or whether I need to go up and meet with the Care Inspectorate, which I did last week because of the specific issues which affected the reputation of the company and because of the level of seriousness of it — I meet with Care Inspectorate every two, three months, umm with a provider relationship manager.

While Tom's work has dimensions of reputational narrative work to it, he is careful to outline the significance of the care home's relationship with its local community. Although he can do some of this reputation work himself through relationships with families or his contact with the Care Inspectorate, much relies on the trust between the care in the home and the community within which it is embedded.

Tom: Size in the care sector doesn't count, I would hope people don't see us as being bully boys because you don't actually hold any power — the home's only as good as the home, y'know, I can't influence that, well, we can use some marketing and stuff, but that home has to integrate locally and the people in that community have to feel content. The home down the road, Sunset Pine, was affected by false allegations, and some true allegations, about a year and a half ago, and that's still recovering from that time, now local community still will have it in their mind about the staff that worked there at the time, so it's a long time to fix a broken service — you can gain reputation very quickly but you can lose it very quickly as well, it takes a longer time to gain it, but to lose it is very quick.

Working with and shaping narratives was a feature of Tom's account of his work at Stillwater. The embeddedness of the care home — its the history and relationship with the local community stand out. This embeddedness was a temporal factor for Tom. Time is sped up when a reputation fails and slowed down when a reputation is generated. In this way he draws back to his own work of managing a narrative.

DAVID AND BEING 'SAVAGED' BY DE-COMMISSIONING

Care homes have diverse and varied position within their localities. In David's case, his organisation has provided care within the same small community since the 1920s. When he describes the senior management of the organisation, he references the 150 years of collective experience they bring to the organisation. In David's terms, there is a 'weight' to that history.

David: The key thing to remember is that when you talk about commissioning and tendering is the way people have moved together and the relationships that have built up over those years – [my boss] and I were talking yesterday – there's something like 30% of our staff are over 60 – it's a lot — and 50% are over 50. And so there is that huge weight of history that sits behind the organisation and huge advantages to that history and I have to say sometimes huge disadvantages to that history in terms of moving and modernisation, but I suppose that's my job.

In David's account, these relationships stretch back through time. Staff at Oak Leaf have been with the organisation for decades. When David talks about his own employment with the organisation, he says that he's an 'absolute newcomer and will be for decades yet'. The depth of these relationships were a central feature in our conversation.

Oak Leaf recently had its services re-tendered. For David, the process of re-tendering has a tragic element.

David: We were savaged in that tender – um services pretty much roundabout halved – and the story from there is about moving from residential care into housing support.

Tendering involves the contracting out of services to a private, for-profit or not-for-profit, provider. Re-tendering is a slightly different process. It involves a formalised change to existing service configuration. For clarification, the following excerpt explains the difference between tendering and re-tendering of services.

CR: And so re-tendering is when the services that you were originally contracted to do get cut?

David: Well, not necessarily cut, though I think where services have been re-tendered, I think in a lot of cases the organisation that held the contract has not done well out of it and that was certainly the case at Oak Leaf. Retendering is where there's an existing service provider – where

as tendering is where there is no service provider. So Oak Leaf's services were retendered and we already had the contract – and that's the most painful. It's one thing to lose out on a new service it's another thing entirely to lose an existing one.

In this particular case, the retendering of services involved a significant restructuring within the service provider. While Oak Leaf had previously operated a number of care homes within the local area, the result of the retendering exercise meant that they had to shift services to community-based care. David explains that restructuring in this case was two-fold. On the one hand, it involved a provision of a new type of care service. On the other hand, it entailed the reduction in the overall provision of residential care services. This meant reducing their numbers of service users and staff.

David: So it's been a difficult, incredibly difficult couple of years for Oak Leaf — a lot of criticism, a lot of very difficult decisions and a lot of goodbyes, cause if you think of the people in the tender – the people that were supported had been with Oak Leaf, many of them, since there were children, and the staff in many cases had been with Oak Leaf since they were young men and women, and for some of them, they're families — quite a number of folk in the local community owed their livelihood over two/three generations to Oak Leaf so it's place in the community is very significant.

Change in this case is directed by the tender, and the tender is a reflection of the changes in local authority policy. In this case, community care was promoted over institutional care — a key directive of the reshaping care policy. David's rendering of Oak Leaf's history in our conversation gives substance to the shifting landscape of care policy. Some organisations are left behind, or changed radically by these shifts. The text of Oak Leaf's long history is wrought from the depth of its relationships. It is these relationships that make the 'savage' of re-tendering meaningful for David. For me, Oak Leaf is an example of the embeddedness of these organisations. They sit within a set of formalised relationships — employment contracts with staff, service contracts with local authority, service agreements with users and residents. And they sit within a set of informal relationships. There was no concrete way for David and I to account for the depth of experience or the quality of relationships between staff and service users or staff and the community. Most of these relationships seem multiple and blurred at Oak Leaf. Staff are the family members of residents, managers like David are newcomers reliant on the experience and relationships of others, the home is an employer as well as a provider of care. This is the story that he chose to tell me when I asked about his work.

My conversations with David and Tom generated different care home narratives. Oak Leaf is small home with a long history where as Stillwater is a large conglomerate of care homes. While David talked about the combined experience of the staff at Oak Leaf and his own place within it, Tom talked about the breadth of care services that he manages. In each case, the embeddedness of the care home is significant. Oak Leaf's narrative reveals the local and lived implications of a shifting policy landscape. In turn, Stillwater's story shows the significance of narrative for the reputation and, by extension, the livelihood of the organisation.

DISCUSSION: RESISTANCE TACTICS

Resistance need not be tied to formal organisation and activism, it can occur in small ways, localised settings, though the practices of people in their everyday living (Abu-Lughod 1990). An analysis of resistance is useful because it directs our attention to the practices of power. In this sense, Abu-Lughod inverts Foucault and claims that “where there is resistance, there is power” (Abu-Lughod 1990, p. 42 inverted from Foucault 1978, pp. 95-96). If we take up the resistance of care home managers and use it, as Abu Lughod suggests, to understand the operations of power in the care system, we might see more than the hegemonic power of the market and bureaucracy. The story of resistance is complex — and the resistance tactics multi-faceted. Care home managers resist the document itself and the technical stabilisation it instils. They resist the activation of the text through the ‘tick-box’ double-checking of their work. They resist an on-going relationship with local governments, questioning their legitimacy and drawing attention to the power they wield and the wall of bureaucracy that surrounds their activity. Care homes resist the translation of the NCHC text — and any sense of deference to local governments through their own narratives. In these stories — they resist the NCHC and the Care Inspectorate. They also tell stories of the care they provide, separating themselves from the ‘faceless’ uncaring local government.

For care home managers, their legitimacy is derived from their proximity to the people who are accessing these forms of support. This proximity affords them a knowledge and expertise which is absent from their accounts of local governments who, from their perspective, count things and sit behind desks knowing nothing of the realities of

providing care and running a business. This resistance is manifest in the repeated debates about the 'real cost of care' — a term used to highlight the discrepancies between social care budget for individual care packages and the actual costs of providing adequate care of a high standard. Care home managers drew attention to the differences between the 'price' of the care they were asked to accept and the 'cost' of care provided within local authority care homes — detail thought to be hidden within local government accounting departments and available only through freedom of information requests.

When care home managers resist — they are resisting on multiple fronts. This is reflected in their conflation of local authorities and the Care Inspectorate. The sense of the 'triangle' of operations — care homes, local authorities and the Care Inspectorate is apt — particularly when care homes are viewed at the inverted point of that triangle. In this image, they are on the receiving end of regulation from two sources. Their repeated criticisms that these organisations overlap in their approach is matched only by their criticism that there is inconsistency across different regulators.

There is a sense of being 'managed' from care home managers — which is not unexpected based on the reasoning from the literature on care markets which suggests that these are in fact 'managed markets' — highly regulated and dependent on public funding. The resistance of care homes is maintained — in keeping with the maintenance of their relationships to local government and the care regulator — a feature which I suggest is fitting with the interdependent aspect of their relationship.

In this sense, I take up Allen's sense (via Arendt) that power is relational — created and held in association — rather than possessed by people or things (Allen 2003, pp.52–59). Markets and bureaucracies do not possess an innate power — instead they mobilise people and hold them in a pattern of relationships. Following Smith, these relationships are mediated through documents — which institutes a replicable and translocal organisation. This power "corresponds to the human ability not just to act, but to act in concert. Power is never the property of an individual; it belongs to a group and remains in existence only so long as the group keeps together" (Arendt 1970, p44 in Allen 2003, p53). In examining the operation of power in this space, I take on an intersectional approach (Brah & Phoenix 2004; Hunter 2012) and suggest that power functions in particular ways, in particular spaces, depending on the relationships at work in those contexts. In this

sense, I do not defer to the assumption that care home managers hold more power in their engagement with local governments just because they may wield authority within their care homes (and most notably over the people who live there). Likewise, I do not assume that local government workers maintain a higher degree of authority because they represent a government or a bureaucracy — one which may be criticised for failing to engage equally with its citizenry. Instead, I have looked to the practices, the work, of these particular participants as way of understanding ‘how’ they manifest power and control and where they resist other’s authority.

This resistance work is directed back towards local authorities and contract managers in the same way that contract managers direct their efforts of enrolment towards care home managers. As a boundary object, the contract sits between these two kinds of work; it is the formal link between these two parties. It represents the tool which is used to enrol care homes and one of the objects of their resistance. But care homes do not use the formal structures of the NCHC text to resist — they resist in other ways — in narrative — and in the activities of their practice. Care home managers talked about the value of their reputation and the work they do to create and maintain that reputation. They also talked about physically barring contract managers from entry to the homes they managed. These tactics are echoed by the resistant ‘talk’ of these interviews — in which care home managers questioned the legitimacy of local governments and the care inspectorate and detailed their experiences of this “faceless” bureaucracy and its “tick-box” approach.

These tactics fall far outside the modes of activation and translation that contract managers described. In so doing, they delineate some of the scope of the NCHC. Working with and managing the NCHC is a feature of the paid work of some local authority staff — although even they admit that it is only ‘part’ of their work. It is also a feature of COSLA and Scottish Care’s work — as described in Chapter 4. These interviewees have a formal role to create and implement the NCHC. The management of contracts is the central element of a contract managers role. Likewise, the negotiation of the NCHC is a dominant part of COSLA and Scottish Care’s role as organisations in the sector — as strategic policy actors their mandate is to develop and maintain a framework for care homes in Scotland. In the case of care home managers, their role is to adopt the NCHC. Though its activation relies on the adoption and use of the text, their work has a different focus. Care home managers have a wide scope of activity to manage and maintain — they manage and

support the staff who are employed in the home, they support residents and families, they manage the financing of the home and its stability within the market. The management of inspections and contracts is only one part of their role.

7. STABILISING TACTICS IN UNSTABLE TERRAIN

INTRODUCTION

In the previous three chapters, I have provided a thick description of the work which goes into building and maintaining a coordinated system of care home services in Scotland. This work could be critiqued for stopping here, for failing to trace the impacts of this system on the people who work within care homes and, most importantly, the people who access that system of support. This is a fair criticism and I answer it with the problematic that began this thesis. Much has been made of the market for care services and the bureaucracies that maintain these institutional modes of care — much blame has been put there — but there is still very little real accounting of the particularities of these systems, their histories and logics, and still less on the people who work within these systems. As I noted in Chapter 2, most of the current research is focused on commissioning systems as an abstraction rather than a practice. These accounts lack a thorough discussion of the context of creating and managing a system of care. As such, they are silent on the local needs, local organisations and local market dynamics of these systems. Moreover, the voices and experiences of the people who work to make these systems are strikingly absent.

I have sought to address those absences and make that system more transparent, so that any effort to develop or critique this system is grounded in its realities, rather than the straw men we create around it. To that end, I have sought to present a narrative that would be familiar to those within these systems, since it is these individuals who are best placed to lead and to be allies to any change in its dynamics. In this thesis, I have taken up Smith's contention that a "diagnosis" is the first step to transformational change: "Making [social relations] visible is a first step in addressing how we can overcome, bypass, and, at a minimum, avoid consciously replicating and reaffirming a politics" (Smith 1996, p.58). To avoid the 'othering' of people within these markets and bureaucracies, I have deliberately sought to understand their work in their own terms and to see the system which organises that work from their vantage point. I do not seek to take their words and show the 'false consciousness' of their viewpoint, nor do I seek to fix their work through

the privileged lens of the academy. Instead, I have presented a system of day-to-day activity that produces and re-produces a system of relations — one which relies on people's own understandings — with the intention that we might attend to that system and intervene where we think relationships or patterns of power need to be unsettled.

In this chapter, I return to my research questions and the theoretical framework that I developed in chapter 3. I suggest the care home system is organised through a set of interdependent relationships, formulated in a national framework agreement, and codified in the contractual responsibilities of the NCHC text. I suggest that this interdependence takes work — technical, relational and emotional/ethical work to negotiate, and maintain, this interdependency. Here, I draw together these findings and conclude that new theoretical tools are needed to understand this interdependence and the work it requires. To that end, I re-frame policy translation as 'care-ful' work, inspired the Ethics of Care (Barnes 2012; Held 2006; Tronto 1993) and attend to these stories of stabilisation as whole, showing them to be part of a holistic process.

In the first section of this chapter, I outline that interdependence from an emotional and ethical vantage point. I have used emotions throughout this research as prompts to direct me to the operations of power and conflict in this field of activity. I have also used it to understand that sense of 'support' in the work I encountered. In the first section of this chapter, I examine those narratives of care and resistance through the lens of a theoretical framework, the Ethics of Care, which is designed to give a holistic account of those interactions (Tronto 1993; Sevenhuijsen 1998).

In the second section, I draw together my understanding of the stabilisation work I encountered and offer a re-conceptualisation of the practices of translation. In this section, I return to the theoretical framework and the blending of ANT and IE that I have used to understand the care homes system in Scotland. I also reflect on the use of emotions and an Ethics of Care framework and depict a set of practices which are underpinned by ethics and developed through local communities of practice. In highlighting the potential for ethics and values in this work, I also ask questions about how these ethics are reflective of the communities of knowledge which produce them.

In the third section, I return to the wider policy context in which this caring and resistance work is situated. As I suggested in Chapter 2, policy and market instabilities are very current concerns for the sector. In this section, I draw attention to these concerns and show the way they unsettle the terrain of care home services and have the potential to unmake the stabilising work done by the national policy, local contract managers and care home managers who use the NCHC.

In the fourth section, I further extend my analysis of the social care context in Scotland to look at the integration of health and social care systems under the Public Bodies (Joint Working) (Scotland) Act 2014. In this section, I apply the same concepts of relational, emotional and ethical policy work to an analysis of this transformative shift in care services, concluding as I have done throughout this chapter that we need more discussion of emotions and relationships in the translation of policy.

STABILISING WITH CARE: POLICY TRANSLATION AS ‘CARE-FUL’ WORK

Throughout chapters 4, 5, and 6, I suggested that the work these practitioners do is value-laden, that it is underpinned by an ethical dimension that these interviewees use to make sense of their work, the responsibilities they have to one another and to the sector as a whole. In this chapter, I bring these activities together and show the way that value-based, and emotional, work occurs in practice. I depict these practices as a form of care — in the sense that these participants seem to care ‘about’ their work and the care homes with which they interact. What’s more, I suggest that these participants were attentive to the needs of these care homes and took some responsibility for meeting those needs within the framework of the NCHC, using their discretion where necessary to deviate from the contract and provide some measure of support to struggling care homes. As I have suggested in Chapter 6, this work is not received as supportive or caring. Relationships with local government are resisted by the care home managers I interviewed, which directs us to the absence of trust in this sector. Analysing policy work as a process to ‘care about’, ‘take care’, ‘care-give’, and ‘receive care’ reflects Tronto and Fischer’s ethics of care framework (Fischer & Tronto 1990) (which Tronto has gone on to develop (see Tronto 1993; Tronto 2013)). I apply that framework here to draw attention to the process of policy translation and the relational work it entails.

This analysis takes inspiration three particular elements the ethics of care approach. First, I take up Tronto's suggestion that institutional forms of care are best understood "in the context of conflict" (2010, p.60). By drawing attention to the fraught relationship between local government and private sector providers of care, I examine the functional and dysfunction elements of the caring process. This reflects Sevenhuijsen's interest in the "existence of conflicting and contested notions of care" (1998, p.20) and her suggestion that we take a hermeneutical approach to understanding the different, "situated" (1988), meanings of care.

Second, I adopt the transformative stance proposed by Sevenhuijsen (2003). I highlight the tensions and points of conflict within the caring process and seek out possible points of intervention and "renewal" of social policy (Sevenhuijsen 2003, p.185) by paying attention to the "particularities" (Tronto 2010, pp.161–2) of the caring context. I use "small narratives" to ground this theoretical account in the "practices" (Sevenhuijsen 1998, pp.19–25) of people in concrete circumstances.

Finally, I adopt the ethics of care framework to emphasise the relational dimensions of human interactions. I take up the claim that care is "applicable to all aspects of human relationships and organisation" (Barnes et al. forthcoming, p.1). In this empirical case of bureaucratic administration and commercialised care home delivery, I aim to show "significance of care ethics as a transformative way of viewing social relations within and beyond those contexts usually defined by reference to 'care'" (Barnes et al. forthcoming, p.1).

As discussed in Chapter 4, the NCHC document sets a national fee-rate for care home placements which creates stability in the market for care home services and puts some limits on the level of profit-maximisation observed in other markets for care home services (Harrington et al. 2001; Laing & Buisson 2014)The contract uses financial incentives and penalties to encourage quality of care. It does this by tying the grading system used by the care regulator in Scotland (The Care Inspectorate 2013) to the fee-rate for care home placements. Higher grades from the Care Inspectorate allow care homes to claim a slightly higher weekly fee from local authorities for the care they provide. Lower grades can elicit a reduction in the weekly fee rate. When I interviewed people within the Scottish care homes sector, I found that this mechanism is a highly contested. Discussion

of the incentives/penalty mechanisms in the contract elicited highly charged responses and anger from care home managers. In contrast, participants from local government described using discretion (Lipsky 2010) when administering the penalty aspect of this mechanism in order to care for 'suffering' care homes. It is this dynamic — care giving and resistance — which I explore here.

LOCAL AUTHORITY PERSPECTIVES

When describing the contractual relationship, contracts managers spoke about the work they do to manage the contract's incentives for quality of care. As I explained in Chapters 5 and 6, the incentive/penalty mechanism uses the Care Inspectorate's grading framework. Grades one through six are awarded according to (quality of care and support, quality of environment, quality of staffing and quality of management and leadership (The Care Inspectorate 2013) one indicates poor quality and six indicates high quality. Care homes receive a small additional payment for high grades of five or six. They also receive a deduction when their grades are one or two.

Contract managers described the activity of managing the award/deduction payments as 'one of the biggest' parts of their day-to-day work. In exploring the narratives of their work, I found that contract managers, quite unexpectedly, put care — of the care home and sector as a whole — above the economic demands of the market. Contract managers 'care about' the wellbeing of care homes by being attentive to a care home's need for financial stability. By discussing the underlying causes of the care home's vulnerability and negotiating a way to meet that need, I argue that they are assuming some responsibility for it.

The organisation of the contract compels the contract manager to take "punitive measures" when the quality grades drop below a grade three. But contract managers described a practice of using their discretion in administering the penalty. For some contract managers, the concern is for a 'suffering' care home and the perception that a penalty could do more harm if the cause of the poor grade is a lack of financial resources (e.g. to pay staff, provide professional development and incentives for staff retention). In this way, contract managers 'care about' the care home and take some responsibility for the implications of their actions on its viability. Further caring work is exhibited in their

efforts to meet with the care home manager and discuss the context of the poor grade. Although the contract entitles them to an automatic use of the penalty, Contract Managers discuss a practice of dialogue and negotiation about 'why' a home has received a poor grade before they administer the financial penalty and reduce the fee-rate.

Contract managers also indicated that they provide concrete support to care homes 'in need'; they don't 'just' implement the penalties stipulated within NCHC without some consideration of the context and an effort to improve the quality of the care home. Care homes 'in need' are organisations that struggle to meet the quality standards set by the National Care Standards and regulated by the Care Inspectorate (2013). There are a number of reasons why care homes might struggle to meet these standards. As these contract managers suggest, the issue might be a financial one. The care home is losing money and faltering as a business. Or perhaps the organisation is finding it hard to recruit and retain staff. A more severe case might involve a serious incident in the care provided to the older person who is resident in the home. This can sometimes indicate a 'systems failure', some kind of communication error which is fault of the organisation's processes, rather than an individual act of cruelty or neglect.

In unpacking the caring process in this way, I have drawn attention to the process of "when and how care is done" (Tronto 2013, p.23) and the ways in which it is embedded in contract manager's day-to-day bureaucratic work. I have shown that contract managers will be attentive to care home needs and take responsibility for meeting those needs, at least within the scope of their work and relationship. Stabilising the pool of trained staff in Scotland or increasing the social value of care work are beyond a contract manager's professional role. On the other hand, the use of discretion to void a penalty on their weekly payment sits squarely within their remit and, I argue, is used as a mechanism of support.

In the next section, I draw attention to the response from care homes. Focusing on the attentiveness and responsibility of contract managers is not enough — "once care work is done, there will be a response from the person, thing, group, animal, plant or environment that has been cared for" (Tronto 2013, p.22).

CARE HOME PERSPECTIVES

Care Home Managers in this project give a different account of the activities I have described above. They do not describe a feeling of support — of being cared ‘for’. Rather they describe a sense of oppressive regulation. For the care home managers that I spoke to, the financial penalty, and its implementation, are viewed with intense suspicion. In Chapter 6, I suggested that a care home manager suspected that local authorities, whose “budget was a bit tighter” would use this penalty as way to save money and “punish them financially”. This sense of suspicion highlights the conflict at the heart of this practice. The efforts to recognise, take responsibility for and meet the needs of care homes which contract managers described to me does not translate across the boundary of the contract to the experience of care home managers engaging with the document and its practices. Instead, care home managers viewed these conversations about grades and penalties as oppressive, something which requires them to ‘prove’ and legitimate their own work.

Rather than having their needs met, care home managers seemed to feel that they were working to meet the needs of contract managers. This is particularly evident in care home managers’ fears of being deemed in “material breach of contract”. The “tick box” or “clipboard’ mindset” seems to overwhelm any sense of care that might be at the root of a contract managers’ actions. How can we explain the conflict between these two perspectives? Is the work that contract managers described really ‘care’? What does the resistance of care home managers tell us about this caring process?

Tronto writes that “care involves conflict” and that “in reality there is likely to be conflict within each of these phases and between them” (1993, p109). This is where an account of care as a process with four phases is particularly useful. Drawing on Tronto’s work, I depict care as a set of inter-related phases: caring about, taking care, care-giving and care-receiving. Care, as a holistic process, requires the presence of each of these four phases. In the narratives presented here, the caring relationship falls apart between the third and fourth phases. We could conclude that there is no care to be observed here, but that conclusion denies the experience of contract managers and obscures, for me, the analytical value of a ‘process’ of care. In examining these four phases, I have drawn attention to the conflict in the caring process in order to highlight the functional, as well the dysfunctional parts of the process.

The practices of contract management I depict refute the conception of the autonomous market actor and technical bureaucrat. Contract managers view care homes within the context of high staff turnover, complex regulatory regimes, low levels of public financing and the changing demographics of an aging population. Their response to care homes reflects a practice of ‘thinking, acting and judging’ with care (Sevenhuijsen 1998) in order to support “suffering” care homes. But, as Sevenhuijsen notes, “power and conflict are in every phase of the caring process” (1998, p.138). Care home managers’ responses reflect a failure of that caring work to translate across the boundary of their relationship. As Sevenhuijsen suggests, “we know that “‘good’ motives, such as attentiveness to vulnerability is no guarantee of good care: it can also lead to paternalism or undue protection” (1998, p.20).

Barnes (2012) and Sevenhuijsen (2003) suggest that trust is a central principle in the functioning of care. Where trust exists, care giving and receiving are negotiated. Where it is absent, there are fractures and ruptures in the relationship. Contract Managers are aware of this need for trust, suggesting that they don’t want to be “police trying to push them to do things or making [care homes] feel victimized”. The care process is not a zero-sum game. One participants’ narrative of care and another’s narrative of resistance do not cancel each other out. The story I have presented here is a story of conflict — not failure — and in that sense it can be resolved. In providing an analysis of the functional and dysfunctional practices in the care process, I have sought to hone in on the particularities of this conflict and seek the possibility for transformation. In the case of contract managers and care home managers, I conclude — as they seem to — that a lack of trust is at the heart of their fragile relationship.

In depicting these caring and resisting practices in bureaucracies and markets, I aim to show that there are possibilities for renewal when problems are framed — not just as an administrative or market failure — but as a problem for people, their relationships and the day-to-day work they do to negotiate needs within their practice. While the debates about market mechanisms for care and the commodification of these activities continue (see Barnes 2012; Held 2006; Koggel & Orme 2013), I argue that these would be enriched by an analysis of care within the very operations of the system itself. The bureaucracy, the market, the local government, the care home are human spaces as much as they are bureaucratic and market spaces. To that end, a relational, caring, framework of analysis

helps to reveal the interdependencies between these parts of the system. In fact, I would further suggest that giving an account of the caring practice of people who work within and maintain bureaucracies and markets is one of the strongest ways for us to build up the moral reasoning within them.

Perhaps it is the space for an explicit deliberation of needs and their interpretations that is missing here, since “to provide good care in an institutional context requires that we make explicit certain elements of care that go unspoken” (Tronto 2010, p.159). For me, that means that care is still a hidden part of much of what do in our everyday interactions. I would seek to raise it out of the implicit, unspoken, parts of our interaction and re-emphasise that “care, thus conceived, is not a marginal activity of life but one of the central procedures of human existence” (Sevenhuijsen 1998, p.137). In the following section, I draw out the implications for this new theorisation of policy translation and show some of the analytical points of intervention that this re-formulation can offer.

RECONCEPTUALISING THE THEORY OF TRANSLATION

In exploring the creation, implementation and use of the NCHC, I have shown that these phases are interlinked – each building on and transforming the work of the others. Throughout this thesis, I have been driving towards a conceptualisation of the Scottish social care system as an assemblage — an interdependent network of actors whose combined effort produces that system in the everyday. Though undoubtedly wider in scope than the network of relationships which I have explored in this thesis, the concept of an interdependence is useful as it gives a new framework for understanding the shared drivers within the system and the conflicts that result from the different positions, experiences and knowledge within that network.

In the following section, I describe my re-conceptualisation of translation theory, emphasising my view that we need a more robust accounting of power, emotion and ethics to understand the everyday work that translation requires. I have looked to ANT to understand the process of translation (see Callon 1986). I have focused on boundary objects (Star & Griesemer 1989; Bowker & Star 1999) to understand the importance of tools and their relationships to people and practice. But I have also added a concept of hierarchy, of institutional dominance, to my use of translation — drawing on Dorothy

Smith's work and IE to emphasise the way some translation can prescribe, demand and penalise. Policy translation then, is first and foremost a kind of work — carried out by people, their tools and the relationships they make around them. It is technical and rational in so far as it uses mechanisms like documents, audit forms and databases. And it is relational and emotional in that it prompts interpretation, discretion, care and resistance.

In adopting a framework that uses ANT, I am suggesting that we might think of the NCHC contract as a technology. Like Star, I suggest that this technology “freezes inscriptions, knowledge, information, alliances and actions inside black boxes, where they become invisible, transportable and powerful in hitherto unknown ways as part of socio-technical networks” (Star 2007, p.84). Contracts are said to be a “classic example of boundary objects” (Brown & Duguid 1998, p.104), since they create a space for the two (or more) parties to negotiate a shared meaning. The salience of Star's approach to ANT is her focus on those experiences which are maligned in the creation of a dominant social order. Like Star and other feminist approaches to ANT (Fujimura 1991; Asdal & Moser 2012; Mol 2008), I have tried to resist the trend in ANT to flatten that network and obfuscate the operations of power within these ‘textually mediated relationships’ (Smith 1990a). As Fujimura writes, “I am sociologically interested in understanding why and how some human perspectives win over others in the construction of technologies and truths, why and how some human actors will go along with the will of other actors, and why and how some human actors resist being enrolled” (Fujimura 1991, p.222).

This is where IE shines in its analysis — for its “analytical goal is to make visible the ways the institutional order creates the conditions of individual experience” (McCoy 2006, p.109). As McCoy suggests — the crucial questions in IE are “What happens to the people? What shapes and constrains the possibilities open to them, including the possibilities for knowing and telling their experiences” (McCoy 2006, p.109). The NCHC creates particular parameters for ethical action, parameters which are still based on the logic of the document (to stabilise) and the tools it relies upon (penalties and incentives). This action, like the technical and relational stabilising tactics I have depicted in Chapter 4, 5, and 6 is part of the micro-practice of translation — the stabilisation of the care homes system as a whole.

But translation theory — even with the additions I describe above — is not quite robust enough to account for the emotionality of these interviews and the complex, ethical, judgements I describe above. For that, I have looked to the sociology of emotions (Bondi 2013; Davidson et al. 2005; Game 1997) and the ethics of care (Barnes 2012; Held 2006; Tronto 2013) and they have helped me to identify and explain the emotional work that occurs in the sector and the drivers that underpin that labour. I used the emotional character of these interviews to explore the ways that a system of care coalesces into dominant paradigms and marginal perspectives. These emotional prompts showed me the ways that actors felt they ‘helped’ and supported the system as well as the ways they felt controlled and disempowered. These dynamics served as prompts for understanding the work of contract managers, and even the drafters of the NCHC text as a kind of caring work. The emotional dynamics of these interviews also promoted me to think differently about the anger I encountered with care home managers. I suggested in Chapter 6, that resistance directs us to the dynamics of power. I also suggested that care home managers’ resistance was directed ambiguously towards local governments as well as the Care Inspectorate. It was tempting to elide these responses and treat them as a function of indiscriminate anger. With further analysis, I think they reflect the range of activities that can affect the care home system — some of which seek to stabilise and some which undermine that stability. This is work which requires some level of care — for each other and for the care homes to which they are related. I have described the caring tactics of their work — and they mirror some of the primary elements of the ethics of care framework developed by Fischer and Tronto (Fischer & Tronto 1990; Tronto 1993).

However, caring practices do not necessarily result in ethical work. Caring work is bounded, in part, by the norms of the community and context in which they are situated. These judgements are situated in local contexts, produced and re-produced through interactions and rooted in local knowledge (Wagenaar 2004). For Wagenaar “the problem that administrators face is to arrive at reasonable, acceptable and feasible judgement under conditions of high uncertainty” (2004, p.650). Wagenaar refutes the suggestion that this work is the product of “rule application” — as is so often attributed to bureaucratic work, or “a priori knowledge” instrumentally used to identify and resolve problems according to preconceived ideas of how those problems ‘should’ be solved (2004, p.649). Instead, Wagenaar offers an account of knowledge which is produced through the complex reasoning and alignment of local practices, norms, and knowledge with the situation to

hand. “Understanding is in the doing” (Wagenaar 2004, p.650)— and so practitioners draw from the implicit understanding of their work as much as the explicit rules which sit on the periphery of their practice. Judgements are developed in communities of action, they can rarely be disentangled from the interactions in which they are embedded. The solutions these participants reach are rooted within the dominant logics of their community. As Wagenaar suggests, “being part of a community is what makes practical judgment possible in the first place” (Wagenaar 2004, p.650). This particular community is a bureaucratic marketised community — the NCHC document which binds them, and the practices it requires, frame care as a commodified act — to be delivered for a price and improved through the monetary mechanisms of financial incentive and penalty.

In terms of the NCHC, this limits the deliberative nature of the text. One the hand, the NCHC is an unexpectedly innovative example of deliberative policy. It was created through negotiation, implemented with translation, discretion and compromise, and applied in practice with negotiation and resistance. Though there is deliberation around the production of the NCHC text, the communities who frame that deliberation are limited to policy makers and analysts, with some consultation from contract managers, commissioners and care home owners. Older people themselves are not involved in the production of the NCHC text, nor are public invited to consult on a draft of the annual NCHC text. Unlike other forms of policy, the development and on-going negotiation is a closed loop — and the ethical reasoning of its producers and users will reflect that substantial limitation.

Translation then is made possible through people’s tools, relationships and work (broadly defined) — but it is also rooted in the “communities of meaning” (Yanow 2003) which surround people and their practices. An understanding of these communities is necessary in order to judge the value of this translation work. Translation of knowledge, translation of policy, translation of meaning — these are not value-free endeavours and we need a theoretical framework which can account for the ethics of this work. Translation, as I have depicted it, is both the production of the system of care and the stabilisation of that system in the everyday. There is work there, as I have shown, and that work reflects an interdependence between the national creation of policy, the local implementation of that text, and its the uptake and use in practice. It also reflects the interdependence between two parts of the care system — local authorities and the private sector care homes. I

depict the care home system as a product of interdependent relationships and effort and it is the story of that interdependence which I have sought to tell.

The thesis could conclude here, though it would fail, then, to take account of the context which surrounds these ‘small narratives’. As I note in Chapter 2, current analysis of the organisation of social care systems fails to take account of both practice and context. I would be remiss now if I did not make some effort to situate these practices within the wider context of social care in Scotland. So it is to that context that I turn. The technical, emotional and caring work I have depicted above is embedded within the ‘failure’ of care homes and the politics which surround the question of responsibility for older people’s care. In the next section, I suggest that some of the resistance I encountered is best understood in light of an unsettled policy terrain that is driving towards the ‘re-shaping’ of care for older people, the closure of care homes and the great unknown of ‘health and social care integration’. In exploring these policy shifts, I provide additional insight into the empirical case I have depicted in this thesis, emphasise the robustness of my analysis through discussion of knowledge exchange activities I undertook to validate this work and, further, show the value of this analytical approach to translation for other policy areas.

MAKING TO UN-MAKE: DIVERGENT POLICY GOALS

In the previous two sections, I have explored the practices of policy translation as ethically-laden work and argued that the technical, relational and emotional practices that I have depicted in this thesis can be examined, and more fully understood, with the addition of an ethics of care framework. I have suggested that translation is ‘care-ful’ work — that it is human work and requires a framework which accounts for both the technical, rule-bound, work we do as well as the relational, situated, emotional practices we undertake. In this section, I broaden the focus of this discussion and show the ways in which this ‘care-ful’ stabilising work is situated within an unsettled policy context that is shifting and changing around the development of the NCHC. In showing some of the policy shifts and their implications for the NCHC, I suggest that we can apply an ethical, emotional, and relational account of translation to the wider health and social care policy terrain in Scotland.

The stabilising work I have depicted is embedded within the failure of care homes and the politics that surround the question of responsibility for older people's care. In this section, I suggest that some of the resistance I encountered with care home managers is best understood in light of the wider context in which it is embedded. In this section, I draw from the grey literature on commissioning as well as some of the interview data I generated with commissioners to show the wider policy terrain for social care for older people. Through this, I show that commissioners are focused on Re-Shaping Care for Older People — a policy which looks to new models of care and the reduction of care homes in Scotland (COSLA et al. 2011; Scottish Government 2012). As commissioners fulfil their role as designers and planners of social care, they also grapple with the emotional, relational, and ethical aspects of their work. To explore this, I draw from a knowledge exchange seminar I conducted with colleagues at the University of Edinburgh that focused on the concept of trust in commissioning (Stocks-Rankin et al. 2013b).

The strategic vision for older people's services is community-based care (e.g. Social Care (Self-Directed Support) (Scotland) Act 2013 and Re-Shaping Care for Older People). Commissioners are tasked with enacting that vision at the local level. For example, Audit Scotland's report on commissioning stated that: "current community care policy promotes independent living for older people. Councils are encouraged to work with their partners to provide services to older people in or close to their homes, and to move away from an over-reliance on care homes" (2004, p.3). This sentiment is echoed in the reports second key recommendation: "Strategic planning for an investment in future community care services for older people should be developed in line with the policy on achieving a balance of care in favour of maintaining people in their own homes where possible" (Audit Scotland 2004, p.35). Though commissioners are tasked with developing community-based care, the need for financial "sustainability" is the same: "In order to make external provision cost effective and sustainable councils need to consider what services they need and how they want them delivered in the long-term. Even if councils decide to provide services themselves, they should plan the direction of service developments before beginning to arrange them" (Audit Scotland 2004, p.32).

This need for vision, and stability, is echoed in the Scottish Government's (2010b) guidance on the procurement of care and support services. The primary importance of commissioning for crafting and enacting a local vision of care services is stated again here:

“the Guide to Strategic Commissioning suggests the adoption of a long term view which considers the needs of the whole community. Commissioning should be seen as a cross-cutting activity ... Commissioners should be planned at least 10 - 15 years ahead and considering what mix of services and support will best meet predicted needs and self-directed support choices, whilst delivering best value (Scottish Government 2010b, pp.19–20).

But what is commissioning work? In their own terms, the commissioners I interviewed said they “develop markets”. When commissioners talk about commissioning, they talk about strategies and policy goals. These strategies and policy goals are developed “in house” though they respond to the agendas set within national policy documents (COSLA et al. 2011; Scottish Government 2012). Councils are responsible for their own initiatives and direction (see Midlothian Council 2011). They manage their local markets and prioritise spending according to local need. When commissioners develop markets — they are working within an existing field of commercialised care production. These markets are already in existence and the businesses or organisations that provide care have their own histories and relationships with the council. The people who live in these facilities are local residents, as are the care staff, managers, cleaners, volunteers and visitors. The local identity of councils, their geography, their local population, their demographics were all very present in these conversations.

For Commissioners, the day-to-day work involves planning and they often refer to themselves as planners. Some of their job titles include that term. Others in the council refer to them that way too. Planning involves the creation of service specifications. They are responsible for designing the terms of a service. They cost it. They make decisions about whether that service will be procured in-house or tendered out to the independent sector. When services are tendered, they work through the tendering process, making sure to adhere to Scottish Government guidance on procurement and EU regulations on purchasing from the third sector. The Commissioners I spoke to talk about the development of services as a way to “flex the market”. They also talked about designing new services. This design and development work operates within an existing field of policy and practice. When Commissioners are developing and designing the market, they are also enacting policy goals and working with high-level strategy about the way services for older people are delivered. They make services by facilitating their provision. To

commission is to create the entire field of services for older people in their area. Commissioners do this by bringing providers into a relationship with the council. In turn, providers are brought into a relationship with service users and the money that is attached to service delivery. Commissioning services often involves a set of tools, such as service specifications, contracts and price mechanisms. Commissioners talked about using these tools as “levers” in service development, so that they can “flex” the market to their needs.

The bulk of commissioning work is focused on the development of the social care sector as a whole. This work is in contrast, and sometimes, in conflict with the goals of the NCHC and the needs of care homes in their area. The commissioners I spoke with were actively working to “re-shape” care for older people and replace care homes with alternative models of care. As I demonstrated in the Chapter 4, the NCHC document was formulated as a response to uncertainties in the sector and is designed and implemented with a view to maintaining stable relationships with the care home sector. This stability is particularly vital given the potential for failure in the sector, as noted in the discussion of Southern Cross and the lack of capacity within the public sector to absorb any wide-reaching problems of this nature (see Chapter 2). The interdependence of local governments and care home providers for the delivery of residential care is central to the provision of this care. And yet, commissioners work with a different set of policy goals designed to unsettle that stability — they are required to develop different models of care and different relationships outside the NCHC framework. From the perspective of care homes, this is a destabilising role and, I argue, a crucial part of what erodes trust within this network.

The translation of the NCHC — from national creation to local use — sits within a policy context that is deliberately moving away from ‘institutionalised’ forms of care. In fact, the uneven terrain does not end with a tension between commissioning social care services and the national framework agreement for care homes. Indeed, commissioning itself is changing as Scotland begins to implement the Social Care (Self-Directed Support) Scotland Act (2013) and the Public Bodies (Joint Working) (Scotland) Act (2014). It is a time of uncertainty for most planners, practitioners and service users in Scotland. Like the translation of the NCHC, I suggest that we need a framework for understanding the work that translation requires, particularly the relational, emotional, and care-ful ethical work that people undertake.

In this thesis, I have developed a framework for understanding that work. I have also tested that framework with commissioners, contract managers, policy makers, care homes managers, carers and people accessing support. Moreover, I have used that framework to create a conversation about the direction of social care in Scotland. In the beginning of this chapter I suggested that a lack of trust was a key feature of the relationship between care homes and local authorities. In fact, the issue of trust is relevant to many in the sector, especially those involved in commissioning services.

I explored this issue of trust as part of my knowledge exchange work for this thesis. In September 2013, approximately 80 commissioners, policy advisors, care providers, health and social care practitioners and academics came together to discuss the issue of trust and commissioning (Stocks-Rankin et al. 2013b). In that discussion, we addressed four questions: What does trust in the context of commissioning look like? How can we promote trust across sectors and agencies? How can structural approaches to commissioning reinforce trusting arrangements? What undermines trust? Through these prompts, we were able to define the practice-based inter-relationship of trust and commissioning. As a group, we were able to have a conversation, across roles and sectors, about the structural barriers and enablers to a trusting relationship, focusing on the specific day-to-day practice arrangements that go into building a trusting commissioning dynamic.

Our primary finding was the role of communication, and power, in the commissioning process (Stocks-Rankin et al. 2013b, p.5). “Open” and “honest” communication were the key terms used to describe trusting commissioning relationships. The terms “joint” and “shared” were also frequently used to define trust. A sense of shared ownership and shared responsibility went hand-in-hand with the need for open communication. The primacy of these concepts continues through the data for the remaining three prompts. “Sharing information”, “working in partnership” and being “transparent” all help to promote trust. Clear “governance”, “shared data” and “co-location” were all structural factors that could facilitate trust. Likewise, a lack of “transparency”, “ownership” or “equity” can undermine a trusting relationship. I was both surprised, and heartened, by the willingness to discuss a ‘soft’ relational issue like trust, particularly in light of the more

technical approaches to commissioning which have been encouraged in Scotland (see Institute of Public Care 2014)

As I have shown, there is substantial technical, relational and emotional work surrounding the development, implementation and use of the NCHC. But, care homes are just one model of care in a new terrain of care policies. Self-Directed Support, Re-Shaping Care for Older People and the Integration of Health and Social Care are all changing the landscape of social care services. Nevertheless, old narratives remain and the ever-present question of cost and responsibility is applied to these discussions just as it was in debates about the Poor Laws, the development of the National Health Service and the NHS and Community Care Act. Care homes are considered by many to be outmoded and expensive (Joint Improvement Team 2014). It is this driver which appears time and again in the discussions about care (Robson 2013).

There is a deep irony to stories of stabilisation I have depicted in this thesis. There is a divergence between the aspirations of the NCHC (and its implementation and use in the care home sector) and the policy direction that commissioners are undertaking to develop new modes of care. The story of David and Oak Leaf care home that I presented in Chapter 6 is all the more eaningful in light of this divergence. The process of “being savaged” in a tender is reflective, not just of the power dynamics between contract managers and care homes, but the power dynamics between different national policy activities.

MOVING BEYOND THE NCHC: LESSONS FOR THE INTEGRATION OF HEALTH AND SOCIAL CARE IN SCOTLAND

These stories of stabilisation have resonance beyond the NCHC document and the practices of policy translation I have depicted in this thesis. The social care system is undergoing a period of radical transformation. New policies in children’s services (GIRFEC), older people’s services (ReShaping Care for Older People), are occurring alongside wholesale shifts in the way social services are organised (Self-Directed Support and the Integration of Health and Social Care in Scotland). In concluding this discussion chapter, I draw out some lessons for these current policy developments — focusing on the value of using ‘interdependence’ as a lens for understanding the translation of the Public Bodies (Joint Working) (Scotland) Act (2014).

In chapter 2, I suggested the question of responsibility has been downloaded, but not resolved. The ‘problem’ of social care for older people has been repeatedly framed as a ‘failure’, prompting a shift in responsibility from one part of the welfare system to another with expectation that a new ‘solution’ will be found. Poor houses and their stigmatisation of older people were meant to ‘solved’ with the National Health Service Act (1946) and National Assistance Act (1948), and their aspirations for a more universal, humane, service. But there were blurred responsibilities for older people’s care, and the chasm in service provision which resulted between these two systems has never quite been resolved. Even the community care reforms in the 1990s, which sought to place the responsibility for social care firmly in the hands of local governments, could not quite resolve the issue of long-term care. The promotion of a market for care now made care for older people the formal responsibility of providers through a contract. A clarity of terms, conditions, price and process around contracting were thought to be the next ‘solution’ to this blurred responsibility. And yet, as this thesis shows, the use of contracting is not just a technical exercise — it is a human, relational, emotional, even caring, activity and blurred responsibilities abound.

In response, I suggest that we need a view of the social care which attends to the interdependencies in the system. As a starting point, interdependence directs attention to diversity and complexity. As I have shown, there are multiple vantage points on the same tools, texts and processes. Likewise, policy makers, commissioners and practitioners can also be people accessing support or carers. There are few fixed boundaries in any system and a focus on interdependence chimes with the multiple ways of knowing (Mol 2002) which occur in organisations as wide, and diverse, as health and social care systems.

Interdependence also focuses on the ways systems and people actually work. In Chapter 2, I referenced Bevan’s vision of a hospital-based social workers in his drafting of the National Health Service Act (1946) (Means & Smith 1998). There are indeed hospital-based social workers, entangled in the same issues of discharge from one system to another and worrying about the outcomes for the people they support as they try and cross the chasm between these organisations (Litteljohn 2013). There is undoubtedly an interdependent aspect to this work. One system of support cannot function without the

other, and yet our conversations about these kinds of support too often fail to consider the relationships, and relational, dimensions of their organisation.

The Public Bodies (Joint Working) (Scotland) Act (2014) seeks to undo some of the tensions I discussed in chapter 2, reforming the divide between the two systems and addressing the chasms that have left people without adequate support. There are high hopes for this Act. It aims to address systemic issues in “delayed discharge”, “cost-shunting between services, “emergency admissions” and “duplication of effort” (Robson 2013, pp.4–5). Notably, these drivers are attached directly to the costs of older people accessing services — sadly underscoring the same narrative of ‘failure’ which I also raised in Chapter 2. For example, a parliamentary report on the Bill notes that the NHS spends more on emergency care for older people than local authorities spend on the totality of their social care budget (Robson 2013, p.5) — a striking statistic indeed. The ‘problem’ is framed as an uneven division of resources, creating a binary ‘us’ and ‘them’. It is this binary which the Public Bodies (Joint Working) (Scotland) Act (2014) seeks resolve.

To address this division, the Act stresses “co-operation” (part 1, section 22). Unfortunatley, the mechanisms for integration are still technical in nature. “Joint Integration boards”, the “transfer of staff”, “joint monitoring committees” (Part 1, sections 12, 13, 17, 21) — all necessary and worthy of attention, but where are the relationships, the relational work, the emotions, conflict and care? Undoubtedly these will be features of integration. For example, some practitioners have already begun to note the emotional quality of their integration experience: “At times of organisational change, your feelings about things affect how you approach it, how you behave and that is certainly the experience we’ve been through” (Burton 2013).

Another way to address this division between the two systems is through joint commissioning. The Act takes up Audit Scotland’s suggestion that commissioning strategies have failed in large part to reflect the “important interdependence of health and social care services” (Audit Scotland 2012, p.16). But how can the Act’s small section on co-operation, which is limited to an exhortation that these organisations ‘should’ co-operate compare with the many pages of text on the committees, boards, audits, and employment standards?

In an effort to address the overly technical nature of the policy debate around Health and Social Care Integration, colleagues and I from the University of Edinburgh held a seminar to discuss some of the relational, emotional, issues facing the sector during this time of change. In April 2013, approximately 100 participants from a range of organisations and roles came together to discuss the role of 'collaboration' within the context of health and social care integration. In a report on the findings from that event, colleagues Ailsa Cook, Sarah Keyes and I conclude that one of the key themes for the participants was "the significance of investing time and financial resources in the complex interpersonal and organisational interactions needed for integration to be successful" (Cook et al. 2013, p.4). Likewise, organisation's need to value the "significance of people at every level of health and social care organisations" and their role as leaders and facilitators of integration (Cook et al. 2013, p.4).

There was an appetite to discuss the relational, emotional, aspects of integration at this event (an appetite that continued through series as I note from the trust and commissioning event discussed above). There are few resources available to policy makers, commissioners, practitioners, carers and people accessing support to discuss, and determine, the nature of co-operation between the many moving parts of these two systems. By focusing, explicitly on relationships, on feelings, on care and conflict, I have drawn attention to the invisible work that many in the sector undertake. The job of a commissioner involves more than a procurement exercise, just as a contract manager does more than the technical work of contract monitoring.

Using a concept like interdependence puts relations, and relational ways of working and knowing, at the heart of the analysis. It makes people, their feelings, their experiences and know-how, the focus of policy work. It acknowledges that it is the complex work that people undertake that makes, and maintains, the market for social care or the bureaucracy of the council. More than that, it reminds us that this system of care is designed for the people who access it for support. By humanising this work, this system of organisation, we move one step closer to maintaining a person-centred approach to care and support that is so often the aspiration of people who work in the sector.

CONCLUSIONS

I have suggested in this thesis that the public and private sectors involved in the organisation and delivery of care homes for older people are interdependent — each relying on the other to produce this system of care for older people. A look at the structures of the system, which I illustrated in the introductory chapter, makes this clear. Care homes rely on the public sector's social care budgets to fund the activities of their organisations. Local governments rely on private, for-profit and not-for-profit, care homes to provide nursing and personal support to older people in this setting.

The analysis I have provided in this thesis began here — in the fragilities and interdependencies of a system of people, organisations and texts. I have explored these relationships with a focus on the everyday work that people do to make and re-make that system, arguing that a focus on these practices illuminates the everyday realities of the system — its power, its frailty, its translation from a set of documents, policies and framework agreements, into the everyday delivery of care services for older people. I have suggested that it is the work of people in these organisations to do the making and re-making — that they create documents and negotiate meaning, taking those documents and making sense of them, then enacting them in their local context in particular ways, using their discretion to make sound judgements. I have also suggested that these activities have repercussions — that the way in which the document is created and implemented has an impact on its intended user. This care home user resists the stabilising logic of the contract, emphasising their own identity and legitimacy as a provider of care — beyond the local government and the NCHC framework.

In reflecting on the thesis as a whole, I have also included a new offering — a reconceptualisation of the theory of translation. In response to the interdependencies that exist in the health and social care sectors, I suggest that we need a vision of translation which can account for emotions and ethics as well as artefacts and relationships. It is through this view of translation that I have approached other policy areas in Scottish social care, suggesting throughout that people, their relationships, tools and work (broadly defined) are at the heart of policy translation.

In order to conceptualise the ethical implications of this work, I have shown policy translation as a holistic process, revealing the 'care-ful' ways that it is carried out and the

context for that ethical reasoning. I suggest that the NCHC is deliberately produced, though it lacks a diversity of perspectives in its creation, implementation and use. The community of meaning around the NCHC then is limited to policy making and service delivery — and its ethics reflect that limitation.

I have also shown the way this policy translation work is situated within a wider policy context and the unsettling effects that has on the practices, and people, I have depicted in this thesis. In focusing on commissioning for social care and the Integration of Health and Social Care, I have, shown the value of this analytical approach for other policy areas and highlighted my own contributions to the debate through the knowledge exchange work I have undertaken on these issues.

8. CONCLUSIONS

In this thesis, I have argued that the work of stabilisation — the drive towards translation — involves a series of judgements and decisions which enact this system in the everyday. The care homes system is rendered concrete and consistent by the everyday work that people do to make it so. To get at the heart of that work, I have emphasised the “small narratives” (Sevenhuijsen 1998, pp.19–25) of the people who work in this system, the everyday judgements they make and the caring/resisting work they carry out to produce the system in a meaningful way. I have focused on these small narratives with two ends in mind.

First, so that the system might be made more transparent to the people who work within it. The silos of national activity, local government commissioning and contracting and care home management are separated by the boundaries of their activity and the hierarchies in which they are positioned. The people I spoke with from the sector did not necessarily know each other’s stories. This in itself is the first contribution of this work — to share, as I have done in some of my knowledge exchange work, the narratives from the sector, sitting them alongside one another and showing the dissonance as well as the harmonies.

Second, I have shown these narratives with a view to understanding the system as a whole. I have taken the NCHC as my starting place and argued that this document pulls the system together, translating the needs of care homes and local governments into a framework agreement and instituting a process of ongoing negotiation about those needs. I have suggested that this knitting together — this stabilisation of relationships — requires an ongoing reproduction which is carried out by contract managers. Finally, I have suggested that the work of pulling together and stabilising is resisted by care home providers who view the mechanisms of stabilisation with suspicion and distrust.

In this chapter, I draw the thesis to close by reviewing the narrative arc that I have presented and drawing some conclusions about the NCHC and its location within the development of care and support for older people in Scotland. I also discuss the wider

contributions of this work, its limits, and some aspirations I have to take it forward beyond the PhD.

STORIES OF STABILISATION: CREATING, IMPLEMENTING AND USING THE NCHC

The stories of stabilisation that I have presented here revolved around three areas — national policy creation, implementation by local government and use (or in this case, resistance) by local service providers. I have argued that in each domain, certain kinds of work go into creating, maintaining and resisting/negotiating this system of organisation — text work aimed at stabilising meaning, relational work focused on translating that meaning and a third kind of work — emotional work — which underpins the first two practices.

Stabilising tactics are enacted by policy actors in three different ways across three different policy spaces: horizontal deliberation of policy actors at a national level to create the NCHC, vertical enactment of the contract in local governments where it is activated by contract managers, and the resistance of care home managers in local areas who push back against the NCHC (and the stabilising work of national actors and local governments). In the previous chapters, I have focused on these spaces in turn — showing the work of stabilising in ‘thick’ detail. In this chapter, I draw out the vertical and horizontal stabilising work of these tactics and show how they combine to produce a system of care for older people.

At a national level, producing the NCHC draws opposing policy actors together to deliberate the terms and conditions of the contract. This process is creative and emotional as well as rational and instrumental as these actors add new material into the text, year-on-year, to ensure the document responds to the needs of the sector. The creation of the NCHC was prompted by a set of instabilities in the sector. High profile reports from the OFT suggested the need for more concerted regulation of the care home sector particularly in terms of the prices charged for care and the striking variations in the quality of care. This report echoed some of the implicit concerns of the community care reforms of the 1990s which focused on shifting the responsibility for care home services from the centralised UK social security budget to local government’s social care budgets.

The need to address the price/cost of care was also a central issue for the care home sector who claimed that the current prices did not reflect the actual 'cost' of providing care to older people. In Scotland, care home providers threatened to 'strike' and stop taking local authority funded residents into their homes. They also formed a representative group, Scottish Care, to argue their case. The drivers for these two policy actors found harmonies in 2007. The public sector needed to set some limits on the price charged for care and institute some mechanisms for improving the quality of care. Care homes needed some stability in terms of price to enable business planning and some level of consistency across different parts of the country.

These policy/market drivers are echoed in the everyday work of people in the care system. For the participants in this project, the challenges of working across different organisational systems to manage care home placements was framed as an 'impossible' task. Similarly, the 'hard' work of managing a care business in the current context of austerity and the chronic under-funding and under-valuing of care are drivers for the continued negotiation of the NCHC. There is more than just money at stake — there is a need to stabilise the relations between local governments and care homes — and an implicit recognition of the interdependence between these two actors in the care system. Without the guaranteed income from local government social work budgets, most care homes could not continue to function. Without the residential facilities in the private (for-profit and not-for-profit) sectors, there would be a severe lack of capacity to provide residential care to older people needing that model of support. This interdependence was framed as the 'nationalism' of the contract document.

The 'nationalism' of this document was echoed by participants who suggested that the contract's function as a national framework agreement ensures that power dynamics across different markets are flattened. Local care markets vary across Scotland. Some areas have a higher proportion of 'self-funders' — people who can afford to pay for the entire costs of their care, usually as a reflection of their affluence and higher socio-economic status. In other parts of the country, the majority of people moving into care homes have lower levels of financial resources and rely on local governments to fund their care. The power dynamics between local governments and care homes are, in part, a function of the proportion of self-funders/local authority funders. Where local markets are largely dependent on public financing, the power tends to reside in the local authority

and they are often able to broker a lower price for care. The opposite is true in local markets where care homes can cater to the expectations of self-funders and rely less on local authority-funded residents.

In activating the NCHC in their local areas, I have suggested that the work of contract managers is focused on two purposes. First, their attentions are trained on meeting the NCHC's information needs. This involves the 'looking at and checking' of care home registrations, compliance with local building codes, training for staff, grades from the Care Inspectorate and so on. They use tools to do this work — databases and customised forms they've created for this purpose. Though they help to collect and manage information, these tools have limits — they do not always capture what needs to be captured. Crucial financial viability information is not collected. Contract managers were not necessarily prepared for financial failures like Southern Cross PLC. Their databases seem to be flawed and a "team" of people is tasked with investigating and improving its functionality. Some contract managers approach this activation work with flexibility. They expect rather than demand. Rather than saying "just do it", they seem to want to support the sector. Sometimes the mechanics of the contract and "the things the care home sector come up with" brought out a more austere response. There are differences in implementation, as I showed in chapter five, but there is also creative and 'care-ful' work (Barnes 2012) to bring this policy to life in local contexts.

Second, contract managers work to stabilise the relationships with care homes in the sector. These two aims are not necessarily harmonious and there a sense that the stabilisation of relationships and the improvement of care provided are more important than price. The implementation of the NCHC is complicated by the realities of market provision and the need, as I understood it, to keep care homes afloat. Managed markets are about 'supporting' the sustainability of the market. Southern Cross' failure had very real and worrying implications for local governments with no capacity in their own homes to take on local residents. That's the extreme example. The everyday practice of fulfilling the duty of care requires interconnected work with private sector care homes. Only 15% of care homes in Scotland are owned and operated by the public sector. This means that 85% of the placements made, of the people who access this model of care, require a working relationship with the independent and charitable sector. Using discretion to penalise care homes for failing grades is just one of the ways in which contract managers

deviated from the NCHC text — forgoing the requirements of the text in favour of the sustainability of their relationships. As I understood it, this kind of discretion is necessary to ensure that older people still have a place to go to receive residential support

The perspectives of care home managers were at odds with the care-ful work that contract managers described to me. Care home managers were careful to distinguish between the necessity of a framework agreement and the process in which that document is implemented. I have suggested that their resistance work is narrative in nature — that they use small mechanisms to carve out their individual role and responsibility to their community. In this way, they push back against their enrolment into the logic of the NCHC. Care homes see themselves as more than extensions of a local government’s duty of care. Their identities as individual organisations — with histories and values and relationships in their community — were important to all of the care home managers I interviewed. Even when they have been ‘savaged’ in a tender, care home managers talked extensively about the identity of their organisation and the values which underpin this work — though in this case they also described themselves as branch of local government. The use of the NCHC to stabilise the sector is complicated by the commissioning strategies which aim to “re-shape” care for older people and shift the balance of care. Coupled with the failure of Southern Cross, care home managers stories evoked a context of ‘faceless’ bureaucracy and instability.

I’ve suggested that my approach to this research was an empathetic one. I did not seek to catch people out on their stories or prove one story to be ‘right’ at the expense of the other. In the previous chapter, I elaborated on this stance — suggesting that a holistic approach which looks at conflict and repair can help us to find fruitful points of intervention. From my perspective, the resistance stories I have told suggest a value-based work and a desire to care — to take responsibility — which has harmonies with the duty of care described to me by participants in local government. The conflict I describe is located in the absence of trust between these two dimensions of the sector. Care homes’ resistance seems to be focused on maintaining a sense of autonomy — of clarifying their role in the physical, emotional, and social wellbeing of older people — of making a kind of work visible where it has been invisible.

CONCLUSIONS ON THE CARE AND SUPPORT FOR OLDER PEOPLE

In Chapter 2, I suggested that the policy history for older people — particularly in respect to long-term residential care — has been reactionary rather than forward-looking. I detailed the trajectory of social care policies for older people — beginning with the stigmatisation of the Poor Laws through the marginalisation and means-testing of the National Assistance Act to the fragmentation and power struggles between the NHS and local government. I concluded that chapter with the current policy climate in which local governments and care homes have both been criticised for failing to provide adequate information about their roles and responsibilities for older people’s residential care (Office of Fair Trading 2004a). My aim in discussing this policy context is to draw attention to the long history of conflict and neglect in the planning and delivery of older people’s services. The assumption that care is the responsibility of the family, something to be prepared for and funded through savings or kinship support, underpinned the amendments to the Poor Law (1834) and continues to be debated today (see The ALLIANCE 2014).

Similarly, the association of ‘older people’ with ‘bed blocking’ or ‘delayed discharge’ perpetuates the idea that older people’s claim to support is less legitimate. The concerns raised by Bevan in the formulation of the National Health Service — that social workers should be on hand to facilitate the transition of older people from hospital to community (Means & Smith 1998) is echoed by the ongoing programme of research and intervention by the Scottish Government’s Joint Improvement Team (2014) and the Institute for Research and Innovation and Social Services — each of which seek to improve the journey from hospital to home (IRISS 2014). And yet, recent figures show that the NHS health board in Fife sent 1,365 patients home between the hours of 9pm and 9am last year — more than 350 of whom were in their 80s. The pressures to discharge patients is thought to have led to the death of one 66 year-old patient after he was discharged at 4am despite being seriously ill (Cramb 2014). The connections between the debates of the 1940s and those we are having now suggest a set of systemic problems which require a holistic analytical response which looks to the historical framing of the policy problem as much as the everyday experience of people working to resolve it.

In reviewing the Griffiths' report (1988) and the drivers for the NHS and Community Care Act (1990), I sought to unsettle some of the current thinking about the community care reforms — specifically that they were primarily driven by an agenda of choice and underpinned by a drive to de-institutionalise care (cf Walker 1982). Instead I have suggested that the reforms were also a response to the open-valve of DSS funding which was pouring into the care home sector. In reading the Griffiths' report for the first time during this research, I was struck by the focus on shifting the responsibility from health service to local government and the need to clarify a set of ambiguous responsibilities for 'continuing care'. Griffiths takes up the Audit Commission's (1986) recommendations to close down the funding loophole in the Department of Social Services which had seemingly allowed an unchecked flow of funds from the UK government into the private sector. The financial drivers are clear and the result is a system in which the sole responsibility for funding and planning lies with local government. Or does it? Throughout this policy history, care homes have operated as a mixed-market. As some of the interview data I present has shown, some of these homes have a 100-year history in their local community. As the question of responsibility — between families or poor houses, health service or local government — continues to be debated, there are still a variety of other voices which are absent. Most notably, of course, are the voices of older people themselves. Carers, paid and unpaid, are missing too. As are the people who set up and run for-profit and not-for-profit care homes.

As I suggest in the introduction, my interest in this thesis is to uncover the invisible work, and structures, which go into the organisation, planning and delivery of care home services for older people. So much is still unknown about this system that finding fruitful points of intervention seems to rely too much on the assumptions of the analyst rather than the experience of people who live and work within them. My own research journey began with a critique of the for-profit care home sector, drawing attention to the dominance of chain-operated nursing homes the lack of knowledge about their operations (Stocks-Rankin 2008). While valuable at the time, it offers little to the pragmatist who wants to intervene in these systems, and relied too much on an old trope that the state's support is inherently 'good' while the market's provision is inherently 'bad'. These can be helpful binaries when campaigning for change from the outside, but they do little for the people in the system who need support from academics to make these changes possible. I have come to feel that there is too much 'blame' in social care debates and not enough

empirically-grounded, imaginative, thinking to resolve the problems we know so well. This thesis is my attempt to look beyond the traditional camps of care home and local government, national policy actor and local administrator, and give an account of the everyday experience of this work and the very human, emotional, caring, work which it entails.

In this research, I focused primarily on the work that people do with a view to understanding the system it produces. In taking up a holistic view of the care homes system, I suggest that it is no longer sufficient to look at the motivations of commissioners in absence of their local markets and community's needs — or the contract document in absence of the work which goes into making and using it. I have used a relational approach, adapting theoretical concepts which look at networks and relationships to the practices of making and using the NCHC. In doing this, I begin the process of plotting and filling in the lacuna I identified in Chapter 2. In this research, I have added to the much-needed conversation about the organisation, planning and delivery of social care systems. Research on social care must take into account a complex web of actors which work to finance and deliver care — a process which is difficult to measure or quantify. To date, the dearth of research on the administration of the social care system, particularly in Scotland, has left practitioners and policy makers with few resources to think differently about the care we offer older people. An investigation of the NCHC document has also revealed that commissioning is not the primary tool used to plan care home services in Scotland. Unlike the English context where most of this research has been conducted, Scotland's care home system is organised through a national framework agreement, which takes the form of a contract document.

I have suggested that the work of creating this document is a kind of policy work which formulates the terms of engagement, the actors involved, and the strategic direction of their activities and relationships. In looking to the implementation and use of this document, I take up Lipsky's (1980) suggestion that these administration activities are also a kind of policy work. This claim allows me to look at the translation of policy from the national domain of creation to the local government's implementation, and its uptake and (resisted) use by care homes. In looking at the practices of translation, I found a range of different kinds of work across different local governments, care homes and other national organisations where I conducted my fieldwork. I have suggested that the unifying

feature of this work was the sense that these people were trying to 'hold things together' and stabilise the system. In giving an account of their work, and my understanding of their experiences in the system, I have tried to show the different tactics they use to stabilise the system as well as the gaps, problems and conflicts which get in the way. I paraphrased Dugdale in Chapter 3, stating that "there is no stasis — though relatively durable connections are possible" (1999, p.131). This may be the nature of networks — both being made and unmade simultaneously as they move organically through their evolution (cf Woolgar & Pawluch 1985; cf Whittle & Spicer 2008). But, I think this account is more than a presentation of a networked paradox — the neutral making and unmaking of a system of care. That is where much ANT analysis would leave us, with a beautifully written account of dominance and impermanence and a pretty puzzle for our post-structuralist minds to muse over. This is why feminist scholars in this tradition have made explicit their interest in power, resistance, and taking sides (Fujimura 1991; Star 2007).

In the end, I do take sides — though not in the ways I would have imagined. I set out to understand a system of care and the opaque, powerful, forces that organise it. I wanted to understand the mechanisms behind the system, to look for the wizard behind the curtain, and I found a whole lot of people — just like me — who were working to understand the same thing. The activities I encountered were siloed — care homes and local authorities do struggle to communicate effectively and national policy actors do make policy at a distance and hope it will be implemented well. And yet there is so much more to this work. There is feeling — there is concern — there is anger. It is this human, sentient work that prompts me to take sides — not with local governments and the state over the independent sector and its profit-making or with the care home sector over the faceless bureaucracy. Instead, I align myself throughout with people who hold this system together and the work they do to improve it. The assessment that I would make is that fragmented systems which operate with multiple boundaries and 'communities of meaning' need translators, boundary objects, and ties that bind them into cooperation. Within that, they need people interested in the expression of values and in the resolution of conflict. They need people who care and have the capacity and skills to 'do' caring work. For me, the NCHC is an unexpected tool to support that work and it goes some way to creating a space to deliberate, though not far enough to unmake the historical dynamics of marginalisation and the continuing instabilities in the sector. More importantly, there are still communities who need to be included in its deliberation and people who should have

a voice in the framing of this document. The system, as Townsend and Walker and Means and Smith, long ago suggested, is weaker for its failure to listen to the voices of older people. That will be the challenge for the next phase of this research.

CONTRIBUTIONS, LIMITS AND AREAS FOR FURTHER RESEARCH

This thesis makes a substantive contribution to the knowledge base around the Scottish social care system. In particular, it provides analysis of the primary coordinating device for Scottish care homes, the National Care Homes Contract (NCHC). In investigating this tool, I suggest that the NCHC is a policy document, formulated nationally, implemented locally across all 32 Scottish local authorities and used in practice in the majority of care homes across Scotland. To date, there has been no analysis of this document, or its role in the creation, and maintenance, of the Scottish care homes market. In fact, given the unique role of the NCHC in the UK — as both a national framework agreement and contract device — this research provides the first robust investigation of this approach to policy.

This research has also made methodological contributions to the study of policy making. In providing an analysis of the NCHC document, this research has adopted an interpretive lens — focusing on the practices that go into policy making and their meaning for the people tasked with their creation, implementation and use. It is unusual for interpretive research in the breadth of its approach to policy making. Few interpretive studies capture the translation of policy across three domains: national government, local government and service delivery as this particular thesis has done.

This research has also made advances in the study of emotions, taking up the call by some interpretive scholars to include emotions in the study of policy (Stone 2013). In this thesis, I have paid attention to emotions in the development of my research design, responding to conflict in the field and adapting my theoretical framework to include an analysis of emotional work.

Given the grounded, iterative, nature of my research design, this thesis has also developed new theoretical terrain for the study of policy translation. Beginning with Actor Network Theory and Institutional Ethnography, I sought to strengthen these two approaches to

translation and harmonised them into a more topographical account of translation — one which can robustly account power laterally across space and time as well as hierarchically within systems of organisation.

Accounting for power opened new theoretical doors for this research. Emotions and conflict were one part of that, as was the role of care in the production and stabilisation of the care homes system. By including emotions in the theoretical framework as well as a process-based account of care and resistance and ethics, I have further evolved the theory of translation. This approach has allowed me to reflect the technical work of making and managing a boundary object, the interpretive relational work of implementing that object and the emotional caring work which underpins those efforts. The value of this more holistic account of translation lies in its ability to focus on people, their relationships and tools, their feelings and conflict. In this thesis, I have focused on the human aspects of policy-making and sought to emphasise the kinds of human work that goes in to making markets and contracts.

By focusing on ethics, I have strengthened my conceptualisation of policy translation as both technical-rational and relational-emotional to show how judgements are made, and the context in which they are formulated. I draw attention to conflict in translation in order to highlight the functional as well as dysfunctional parts of the process and provide insight into fruitful points of intervention. Placing people, their relationships and work, at the heart of a discussion about ethics ensures that those individuals can be part of the conversation. I have not sought to define ethics and apply it — with no understanding of people or their context. Instead, I have worked to understand ethics from the perspectives of the people most intimately involved in this work, building a picture of the policy process that is recognisable to them so that they may take action to address the power imbalances within it.

I have tested the theoretical approach, and the substantive findings from this research, beyond the boundaries of this thesis and these participants. By doing a range of knowledge exchange work during my research, I have had the opportunity to talk about, and test, these findings with commissioners, policy makers, contract managers, people accessing support, carers, providers and other academics. The seminar series Conversations in Health and Social Care was not an exercise in ‘feeding back’ my findings.

It was a robust knowledge exchange event that ensured that the bulk of participants' time was spent conversing and sharing their own knowledge and experience. Although I presented a 20-minute overview of my findings, participants spent over an hour in facilitated conversation — building up a picture of the concepts of trust, collaboration and empowerment. Over the course of the three events in the series, we were able to develop new knowledge about these concepts with the 250+ participants who attended.

In this way, I have tried to address one of the central limits of this project, and the NCHC itself. There are no examples of consultation around the production or use of the NCHC with carers or people accessing support. As I note in Chapter 7, this is one of the central limits to the caring work that I encountered in the field. Though the NCHC is collaboratively produced by representatives from local governments and care homes, users of these services are not included in its development. Similarly, the production of this thesis did not include the perspectives of people accessing support or carers. I have followed trajectory of the NCHC through its production, implementation and use in care homes, developing a picture of the system based on the document's journey. The data in this thesis is reflective of that journey, and sadly reinforces the exclusion of some perspectives. Organising a series of knowledge exchange events was one way for me to address this limit, though more still needs to be done to engage with older people themselves and unsettle this dynamic of exclusion.

Another limit of this research lies in the narrative approach I have taken. By focusing on individual stories within the empirical chapters, I have provided in-depth accounts of individual approaches to translation and stabilisation. Though fruitful for the analysis of the work (broadly defined) that goes into translation, this thesis does not provide a more a representative picture of the sector which is often so valuable to practitioners and policy makers (see Audit Scotland 2004). I can now contribute to debates about the translation of policy, the commercialisation of care services, or markets in social policy — but more work needs to be done to make these findings accessible and useable to the sector itself. Again, the knowledge exchange events go some way to addressing this limit but further exchange is needed to ensure the policy and practice-relevance of this work.

Going forward, I would like to contribute further to the policy debates about the Integration of Health and Social Care in Scotland. Scotland's diverse collection of local

governments, health boards, charitable and independent service delivery organisations are on the cusp of transforming health and social care. The policy guidance around the Public Bodies (Joint Working) (Scotland) Bill (2014) has suggested that the Policy Memorandum accompanying the Bill states that “reform based on centrally-directed structural changes would be unlikely to deliver the shift in outcomes required” (para 157). Integration of this kind is not without its challenges and values and ethics are central to much of the negotiation that is ahead. In doing some knowledge exchange work around this project, I have found there to be appetite amongst the participants in this project to learn more about the system in which they work. In my experience, older people and carers feel particularly excluded from this deliberative process. I think there is an opportunity to further explore and map the different approaches to older people’s care across the localities of Scotland, particularly if that exploration includes the wide range of stakeholders I’ve listed here.

I think this work would also be valuable to the Social Policy discipline where this PhD is based. There has been much discussion about markets and their role in the design and delivery of the welfare state (see Le Grand 2007; cf Martin et al. 2004). I think this account, particularly the use of an ethical, caring, framework, would offer new insight for the study of Social Policy as well as the development of policies themselves. An interest in the role of care in the state reflects a long-standing, though relatively minor, interest in the discipline (see Dean 2012, pp8-9) I would like to extend the theoretical approach of this research to other policy areas to test its relevance.

Theoretically, I think there is more work to be done around the ethics, and emotions, of markets and policy work. I’ve suggested that this analysis humanises these systems. In focusing on the grounded experience of people doing their everyday work, I think it also has the potential to locate points of intervention and build links with people who would be best placed to carry out that transformative work. Facilitating these conversations in the context of research was highly valuable and I think it offers new insights into the way we conceptualise the state-market relationship and helps explain some of the tensions between these two facets of the system. I would like to do more research on the emotional dynamics of this relationship, particularly if it were to make a more explicit use the sociology of emotions, or some other psychodynamic framework, from the start of the research (rather than the emergent approach I have adopted here). I would also suggest

that knowledge exchange work could be done around this project which takes up the idea of conflict and care, emotions and values, and uses them to prompt discussion between groups of actors in the system. My impression is that the care homes sector in Scotland needs additional support and that the brokerage of an independent researcher or agency could help to facilitate some of the changes it wants to adopt.

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APPENDIX 1

	NAME	ROLE	ORGANISATION
1	Angus	Commissioner	Local Authority A
2	Darlene	Commissioner	Local Authority A
3	Steven	Contract Manager	Local Authority A
4	Peter	Commissioner	Local Authority A
5	Sarah	Contract Manager	Local Authority B
6	Wesley	Contract Manager and Team Leader	Local Authority B
7	Monica	Social Worker	Local Authority B
8	Liz	Social Worker	Local Authority B
9	Megan	Senior Manager, Assessment and Care Management	Local Authority B
10	Alison	Head, Older People's Services	Local Authority B
11	Andrea	Senior Manager, Older People's Services	Local Authority B
12	Karen	Manager Adult Services	Local Authority B
13	Lucinda	Contract Manager and Team Leader	Local Authority C
14	Penny	Resource Worker	Local Authority C
15	Brenda	Contract Manager	Local Authority C
16	Jimmy	Contract Manager	Local Authority C
17	Tristan	Contract Manager	Local Authority C
18	Penny	Resource Worker	Local Authority C
19	Lucinda	Contract Manager and Team Leader	Local Authority C
20	Michael	Contract Manager	Local Authority D
21	Darlene	Quality Assurance Officer	Local Authority D
22	Kate	Quality Assurance Officer	Local Authority D
23	David	Care Home Manager	Oakleaf Care Home
24	Tom	Care Home Manager	Stillwater Care Home
25	Stuart	Care Home Manager	Soft Shoal Care Home
26	Stanley	Care Home Manager	Beech Care Home
27	Joe	Care Home Manager	Leafy Pines Care Home
28	Martha	Care Home Manager	Cairngorms Care Home
29	Naomi	Care Home Manager	Buccleuch Manor Care Home
30	Rick	Care Home Manager	Buccleuch Manor Care Home
31	Penelope	Strategic Lead	Care Inspectorate
32	Andy	Strategic Lead	Care Inspectorate
33	Denise	Inspector	Care Inspectorate
34	Ronald	Policy Officer	COSLA
35	Harry	National Policy Actor	Scotland Excel
36	Mark	Head, Community Care and Housing	Local Authority F
37	Reginald	Policy Advisor, COSLA	Local Authority G
38	Alexander	National Policy Actor	Scottish Care
39	Carl	Commissioner	Local Authority E

Research Information Sheet

Study Title:

Care Homes Services for Older People in Scotland

Researcher: Catherine-Rose Stocks-Rankin

Date: April 2012

Description of Project:

This research explores the organisation of care services for older people in Scotland. It focuses on contract management as the focal point of that organisation. This study asks the question 'How is the care homes market managed?' In order to answer this question, the research examines the networks of people involved in the organisation, provision and regulation of care home services and the day-to-day work that they do.

It is hoped that participants would be willing to discuss their experiences with planning, contracting, providing or regulating care services. This project is interested in the knowledge and tools that are used to carry out this work as well as the networks of people that participants encounter in their day-to-day work.

Interviews should last approximately 60 minutes. With permission, these interviews will be recorded and transcribed for use in the PhD project. If desired, the content of the interviews and the names of participants will be kept anonymous and confidential. All interview material and/or a summary of the interview will be offered to participants for validation. This project complies with the ethics standards set by the School of Social and Political Science at the University of Edinburgh.

Contact details:

Email: cr.stocks-rankin@ed.ac.uk

Participant Information Sheet

Care Homes Services for Older People in Scotland

With your permission I will audio record and transcribe our conversations(s) and analyse the data to look for patterns and themes. I may use excerpts from this interview in my final PhD thesis, journal articles and other publications in the public domain.

All interview material is confidential. I will make every effort to ensure that the information provided is not attributable to you individually.

Your participation in this interview is entirely voluntary, if you do NOT wish to participate at any time before, during or after the interview please let me know and I will not use any information you may have already provided.

I plan to provide a copy or summary of our conversation to all interview participants. This can be done in several ways: a CD copy, a transcript of the interview and/or a summary.

If you would like a **CD of the interview**, please indicate so here

If you would like a copy of the **interview transcript** sent to you, please indicate so here

If you would like a **summary** of the interview, please indicate so here

If you would like to be informed of any future knowledge exchange events or seminars, please indicate so here

If you agree to be part of the research, please sign and date here:

(Signature)

(Date)

Thank you for your time and participation,
Catherine-Rose Stocks-Rankin

**University of Edinburgh,
School of Social and Political Studies
RESEARCH AND RESEARCH ETHICS COMMITTEE
Self-Audit Checklist for Level 1 Ethical Review**

*The audit is to be conducted by the **Principal Investigator**, except in the following cases:*

- **Postdoctoral research fellowships** – the applicant in collaboration with the proposed mentor.
- **Postgraduate research** (PhD and Masters by Research) – the student together with the supervisor. *Note: All research postgraduates should conduct ethical self-audit of their proposed research as part of the proposal process. The audit should be integrated with the student's Review Board.*
- **Taught Masters dissertation work and Undergraduate dissertation/project work** – in many cases this would not require ethical audit, but if it does (for example, if it involves original fieldwork), the student conducts the audit together with the dissertation/project supervisor, who keeps it on file.

Potential risks to participants and researchers

- | | | |
|---|---|----|
| 1 | Is it likely that the research will induce any psychological stress or discomfort? | NO |
| 2 | Does the research require any physically invasive or potentially physically harmful procedures? | NO |
| 3 | Does the research involve sensitive topics, such as participants' sexual behaviour or illegal activities, their abuse or exploitation, or their mental health? | NO |
| 4 | Is it likely that this research will lead to the disclosure of information about child abuse or neglect, or other information that would require the researchers to breach confidentiality conditions agreed with participants? | NO |

- 5 Is it likely that participation in this research could adversely affect participants?
NO
- 6 Is it likely that the research findings could be used in a way that would adversely affect participants or particular groups of people?
NO
- 7 Will the true purpose of the research be concealed from the participants?
YES
- 8 Is the research likely to involve any psychological or physical risks to the researcher, and/or research assistants, including those recruited locally?
NO

Participants

- 9 Are any of the participants likely to:
be under 18 years of age? NO
be physically or mentally ill? NO
have a disability? NO
be members of a vulnerable or stigmatized minority? NO
be in a dependent relationship with the researchers? NO
have difficulty in reading and/or comprehending any printed material distributed as part of the research process? NO
be vulnerable in other ways? NO
- 10 Will it be difficult to ascertain whether participants are vulnerable in any of the ways listed above (e.g. where participants are recruited via the internet)?
NO
- 11 Will participants receive any financial or other material benefits because of participation, beyond standard practice for research in your field?
NO

Before completing the next sections, please refer to the University Data Protection Policy to ensure that the relevant conditions relating to the processing of personal data under Schedule 2 and 3 are satisfied. Details are Available at: www.recordsmanagement.ed.ac.uk

Confidentiality and handling of data

- 12 Will the research require the collection of personal information about individuals (including via other organisations such as schools or employers) without their direct consent?
NO
- 13 Will individual responses be attributed or will participants be identifiable, without the direct consent of participants?
NO
- 14 Will datafiles/audio/video tapes, etc. be retained after the completion of the study (or beyond a reasonable time period for publication of the results of the study)? NO
- 15 Will the data be made available for secondary use, without obtaining the consent of participants?
NO

Informed consent

- 16 Will it be difficult to obtain direct consent from participants? NO

Conflict of interest

The University has a 'Policy on the Conflict of Interest', which states that a conflict of interest would arise in cases where an employee of the University might be "compromising research objectivity or independence in return for financial or non-financial benefit for him/herself or for a relative or friend." See: http://www.docs.csg.ed.ac.uk/HumanResources/Policy/Conflict_of_Interest.pdf

Conflict of interest may also include cases where the source of funding raises ethical issues, either because of concerns about the moral standing or activities of the funder, or concerns about the funder's motivation for commissioning the research and the uses to which the research might be put.

The University policy also states that the responsibility for avoiding a conflict of interest, in the first instance, lies with the individual, but that potential conflicts of interest should always be disclosed, normally to the line manager or Head of Department. Failure to disclose a conflict of interest or to cease involvement until the conflict has been resolved may result in disciplinary action and in serious cases could result in dismissal.

- 17 Does your research involve a conflict of interest as outlined above?
NO

Overall assessment

If all the answers are NO, the self audit has been conducted and confirms the ABSENCE OF

REASONABLY FORESEEABLE ETHICAL RISKS. The following text should be emailed to the relevant person, as set out below:

“I confirm that I have carried out the School Ethics self-audit in relation to [my / name of

researcher] proposed research project [name of project and funding body] and that no reasonably foreseeable ethical risks have been identified.”

- Research grants– the Principal Investigator should send this email to the SSPS Research

Office (ssps.research@ed.ac.uk) where it will be kept on file with the application.

- Postdoctoral research fellowships – the Mentor should email the SSPS Research Office

(ssps.research@ed.ac.uk) where it will be kept on file with the application.

- Postgraduate research (PhD and Masters by Research) – there is no need to send the Level

1 email. The ethical statement should be included in the student’s Review Board report.

- Taught Masters dissertation work and Undergraduate dissertation/project work – there is

no need to send the level 1 email. The dissertation supervisor should retain the ethical

statement with the student’s dissertation/project papers.

If one or more answers are YES, risks have been identified and level 2 audit is required. See the School Research Ethics Policy and Procedures webpage http://www.sps.ed.ac.uk/admin/info_research/ethics for full details.

In the last fifty days of my PhD, I began to write an open journal about the process of ‘finishing’ — in part to remember it all, to be able to reflect back on the work and keep myself mindful of the journey — and in part to make sense of my place in the academy. As a feminist researcher, with a background in care work, I’m not sure I always felt at home in the world of academia. It seemed to offer so much — a chance to move forward professionally, an opportunity to secure a steady income, a place to find a community of activists working to critique the status quo. From the outside, a PhD offers all of this and more. It confers status and prestige. It offers one the good fortune to spend energy on a single intellectual challenge. It hones and tempers — leaving behind a stronger mind.

But, those benefits are hard won and it remains, in my experience, a hard place — a place where power and privilege remain largely unexamined — a place where ‘what’ we study seems to do little for ‘how’ we ourselves act. In my naivety, I was shocked to see, and experience, bullying across all the power structures of the university. It’s one of the reasons I’ve found work on the periphery. There is a worrying silence that accrues amongst people whose professional survival relies so heavily on their reputations. We might cling together in small groups — hopeful that we will change the system from the inside out. But they are a great deal of work to maintain — and deeply painful when they collapse. Without a culture that enables us to confront conflict and the tools to negotiate — relationships too often break down.

The great promise of academic practice is founded on interdependent relationships — learners become teachers, teaching funds research. We all rely on someone to read our work, share their learning and keep the system running. In an acknowledgement of this, I made a promise to myself that — should I finish the PhD — I would write a manifesto of my own personal academic practice. I have included it here as a physical reminder of the values that were honed through this process.

TEN VALUES FOR ACADEMIC PRACTICE

1. Reflect — take the time, find the space, encourage collective understanding.
2. Find the joy — when it's lost, look for it. When you've found it, use it.
3. Speak up — be wise, be clear, be care-ful - but speak up.
4. Walk the walk — know your values and the values of your work. Find the harmony between them.
5. Challenge — the work, the behaviour, the system — not the person
6. Learn — from anyone and everyone - be open about what you 'don't know'
7. Teach — be generous with what you do know
8. Boundaries — find a balance between your work, your relationships and your life — don't let them become one and the same
9. Confront — the hard things and move on
10. Support — your community, your environment, your interactions, your ideas — and seek a place where support and interdependence are crucial facets of practice.

Catherine-Rose Stocks-Rankin

May 31, 2015