

The Impact of Social Capital on the Personalisation of Care

by

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Abstract

One of the tenets of personalisation was that people using services could achieve greater citizenship and help to design better supports if they were able to direct innovation in services. Implicit in this was an assumption that people using services would be able to utilise their social capital (resources based on social networks), an asset which was not prioritised by previous approaches to service delivery. This thesis sought to identify if social capital was present and if it was being accessed to support the personalisation of services, comparing and contrasting the situation in services for older people and for people with learning disabilities.

Whilst an initial hypothesis was that service providers for these different groups charged different rates due to different levels of social capital, no difference in social capital was established between these two groups. People did have social capital, but it was not mobilised by individuals or state actors responsible for commissioning support. This led to a consideration of street-level bureaucracy and the environment shaped by austerity and the Care Act. The study concludes that the implementation of personalisation has frustrated the use of social capital, such that it has not contributed to the transformation of care.

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Abbreviations used

ADASS	Association of Directors of Adult Social Services
IB	Individual Budget
NAO	National Audit Office
NEF	New Economics Foundation
NHS	National Health Service
NHS&CC Act	National Health Service and Community Care Act 1990
NPM	New Public Management
SCIE	Social Care Institute for Excellence

Reference conventions

In this thesis Harvard (Anglia, 2008), as embedded in Microsoft Office 2016, is used for referencing, except where multiple sources are quoted. References appear as (Gazdar, 1999, p. 23) or Duffy (2008, p. 23). This system does not support abbreviated organisation titles in subsequent references.

Where reference is made to Chapter .. or (see p. ..) this refers to a point within this thesis.

CHAPTER 1 INTRODUCTION

The idea for the thesis started with a question about why the cost of services for people with a learning disability were noticeably higher than those for older adults. The rates advertised for staff in one area, Site A, in 2012 showed that staff caring for older adults were being offered less and with poorer terms and conditions. There was no obvious reason for this in that the skills and qualifications required were similar. The proposition that supporting people with a learning disability was inherently more complex should have been indicated by a need for higher skills within the person specification for carers. One question was whether the difference could be attributable to the abilities, expectations or social environment of the people being supported. This led to a hypothesis that the social capital individuals maintain could be an influence, in that those with a higher level of social capital, typically older adults, would be better able to manage their own support and therefore those supporting them would need to demonstrate less experience in the task.

Interviews for this study were conducted across two local authority sites so as to reduce the impact of local implementation arrangements, and to increase the potential sample of participants. Participants in both areas were identified as needing support due to their age or having a learning disability. The detail of this is given in Chapter 5.

As the study was being designed the policy of personalising social care was being rolled out across England as part of a transformation programme for adult social care (Department of Health, 2007). Within the philosophy of personalisation set out in *Putting People First* (Department of Health, 2007)

there was a belief that, in harnessing the vision, abilities and resources of individuals needing support, better outcomes for individuals would be created. This includes aspects of social capital, the resources drawn from the social networks and connects of individuals. Based on the local pilot studies undertaken, it was anticipated that a more efficient use of state resources could also be realised (IBSEN, 2008).

Social capital theories propose that an individual has a range of social networks that they can draw on to meet their needs in society (Putnam, 1995). This could go further than social contacts with families and friends and, in the case of people in need of support, offer direct support (a range of care tasks) but also knowledge, contacts and appropriate means to engage with authority structures to maximise the resources they may be entitled to (Coleman, 1988). Therefore, social capital could be a significant contribution to the success of the implementation of personalisation as it was developing. By bringing in a different perspective to the planning of care there was an expectation that this would result in enabling greater creativity and innovation in the delivery of support (Department of Health, 2007).

Social capital is not necessarily a neutral force as, from the beginning, theorists like Bourdieu noted that not all social networks would be able to provide the information and support needed in every situation. It is therefore necessary to establish not only the presence of social capital but also what gains the individual might achieve in the particular situation.

The study was designed to consider whether there was a difference in the social capital of older adults from those with a learning disability, and how that

would impact on the planning and delivery of care and support. However, it quickly became apparent that there was little difference in the social capital of older people and of people with learning disabilities who took part – and that current social care practices seemed to be preventing people using services from drawing on social capital (see Chapters 6 and 7). The focus of this study thus shifted to the perspectives of front-line social care staff and their managers, and to the barriers to personalisation being introduced in the way apparently intended by policy makers. This necessitated a consideration of the literature on policy implementation, with Lipsky's work on street-level bureaucracy providing a particularly important lens (see Chapter 8; see also Evans and Harris, 2004; Ellis, 2007 for previous considerations of the initial assessment of need and the subsequent allocation of resources using this lens). This study was able to look at the relevance of street-level bureaucracy to the next stage of service delivery, the planning and implementation of care, and the impact that the behaviours and procedures used by front-line staff had on the mobilisation of social capital.

During the study there were two major changes in the national arrangements for adult social care that had not been anticipated in the original service design, the Care Act 2014 and austerity.

The Care Act was passed in 2014 to consolidate the existing framework around the delivery of personalised services. This gave a formal definition of what personalisation was expected to look like and aimed to reduce the level of variation in implementation across England. Within the Care Act guidance there is an assumed model of social capital that is informed by the work of the

original social capital theorists, particularly that of Robert Putnam (2000), (see pp.81-2).

The second significant policy was the extension of the national austerity programme. At the start of the study the impact on social care was modest and the government was saying that it would protect the NHS and services to vulnerable people. In the course of the study this position changed as local authorities were expected to shoulder a significant part of the burden of spending cuts. By 2014 adult social care was contributing 40% of all spending reductions in local government (National Audit Office, 2015), in line with its overall share of local government spending. At a time of increasing demand due to demographic changes the impact was a significant reduction in the available resources for adult social care (The Health Foundation, 2015).

As a result of austerity and the Care Act the policy environment saw a significant change over the period in which the study was undertaken. This had a distinct impact on the interviews with local authority staff, and as such had to be recognised in the final thesis.

Development of social capital and social care

Whilst considering the timeline for the development of social capital it is notable that the initial work was published from 1988 to 2001, with implementation based studies starting to appear a few years later, such as Szreter & Woolcock (2004) (see Chapter 3). The link between aspects of social capital and social work have long been established:

Community care has been defined as being concerned with 'the resources available outside formal institutional structures,

particularly in the informal relationships of the family, friends and neighbours, as a means of providing care' (Bulmer, 1987, p. 108).
in (Lymbery, 1998, p. 869)

What has been neglected is the use of social capital theory to examine the role of social work with adults.

The background to personalisation was based on the reforms of the NHS&CC Act 1990 and local pilots in 2005. The literature around personalisation was therefore being developed at the same time as social capital theory was being disseminated and, whilst the personalisation literature recognised aspects of what was to be described as social capital, there are limited specific links between the two discourses. This is discussed in more detail in Chapter 4.

The Research Question

The initial question was:

Do older people and people with learning disabilities have different levels of social capital?

When findings indicated that they didn't, the additional questions were:

- Do people using services, social workers and managers seek to mobilise social capital when personalising care?
- If not, what are some of the barriers preventing this from happening in the manner envisaged by policy makers?

Structure of the thesis

During the research the study was able to quickly identify from people that use state funded services, that, whilst most had good social networks and elements of social capital, this was not being mobilised to support the personalisation of care. Consistent with Eisenhardt's approach to case study research (see pages 88-89), this required a change in the study to understand why social capital was not being mobilised and to take into account the changes in the legislative position that were implemented during the course of the study. Therefore, the thesis starts with a review of the literature on social capital and on personalisation that informed the initial question, but then goes on to look at the literature on street-level bureaucracy which was only considered in detail in light of the findings from the cohort of managers and social workers.

At the start of the study the main body of literature around social capital was dominated by the original social capital theorists, with studies being published

that were starting to apply it in different areas of research. The development of personalisation increased the awareness of social capital, but no consistent definition appeared through the personalisation literature as it started to incorporate aspects of community capital and social entrepreneurship. The creation of a legislative framework around personalisation, through the Care Act, has seen the return to a more specific concept of social capital similar to that of the social capital theorist Robert Putnam.

When the study was developed the definition of social capital used was based on the work of Putnam (2000) and Coleman (1988). This is set out in the literature review and then followed through into the methodology and findings. However, to understand the final contribution of the thesis, the literature review will also look at the development of the term social capital, in England, as it informed the implementation of personalisation.

The Background (Chapter 2) sets out the social care environment with a brief review of the history of social care in England that seeks to understand how personalisation was developed. In doing so it is impossible not to recognise the recent impact on the wider public sector environment of a national policy of austerity, as it is likely to change the behaviours of public sector staff involved in delivering social care, along with the availability of resources.

The literature section (Chapter 3) starts with a review of social capital theory, as it informed the study, followed by a review of economic principles as they impact on social capital, and policy implementation theories, as they apply in the social welfare field. It concludes with a short look at the available work on the implementation of austerity and how it might impact on social care in

particular. Chapter 4 takes a more detailed look at personalisation and its implementation in England.

The methodology (Chapter 5) describes the way the study developed from an analysis of the experience of four populations of people using services (people with a learning disability and older adults, across two local authorities) to a wider question about the behaviours of front-line workers and how they approached individual social capital at a time of legislative change and policy constraints.

The findings of the study are presented in three chapters reflecting the responses of the two cohorts of participants. Initially, the findings from the first cohort relating to social capital, using the work of Putnam and Coleman, are set out (Chapter 6) followed by the issues around street-level bureaucracy (Chapter 7). Chapter 8 sets out the responses from local authority staff to social capital, street-level bureaucracy and the current services of local authorities.

The final discussion brings together the themes around social capital, personalisation and policy implementation to understand the implications for the delivery of social care in a policy environment dominated by austerity. The conclusions aim to place the study as a development of our understanding of issues relating to the role of social capital in the delivery of social care, but also to comment on the implementation of policy in this area, for a professional audience as much as an academic one.

Terminology

The use of language in social care is an emotive and complex field that warrants study in its own right; to engage in this is outside the scope of this study. However, it is important that the assumptions as to how language is used in this thesis is set out at the start to reduce the risk of confusion.

All people that contributed to an interview as part of this study are described as a *participant*. Some of these people were in receipt of services funded through a personal budget and are described as *service users*. Others were supporting the person using services and were referred to as *carers*. Where this support was offered on an unremunerated basis it is referred to as *informal care*. Where the participants in an interview included a service user and one or more informal carer I have described this as a *family*. When discussing social networks, I have used the description of family in its common usage. As a result of the interviews reference is also made to *paid carers* who are employees whose reason for engaging with the participant is as a result of their contract of employment, not because they were part of the person's life prior to offering support. This distinction is being challenged as some family members can be employed as carers as a result of a direct payment, but it is unusual and has restrictions placed on it by legislation. As a whole I am referring to these participants as the *first cohort* as the results set out the scope of the second set of interviews.

The participants were selected as they had support needs either due to their age or as they were considered to have a learning disability. The definition of an *older adult* was someone who was over the age of 65 years. The term

learning disability was chosen as it referred to people who were eligible for social care support as a result of an intellectual impairment. This is often identified as a moderate or severe impairment as diagnosed by a clinician. It is sometimes difficult to assess an impairment, but for this study the decision had already been made by the host local authority. It is significantly more restrictive than the alternative descriptor of a learning difficulty which is defined within legislation for educational purposes, and is the preferred title amongst user advocacy groups.

This study is considering the impact of social structures and government policy on people with an *impairment*. Therefore, in line with the concept of the social model of disability the descriptor of *disability* is used where it is considering the limitations placed on the individual as a result of the societal response to their impairment.

The *second cohort* of participants were all employed by *local authorities* in adult social care departments. In this thesis *local authorities* mean *councils* with social service responsibilities (or CSSRs in some literature) which are responsible for the allocation and provision of support to vulnerable adults. I have used the term *social worker* to describe the *front-line worker* who is expected to assess need and may engage services for the person needing support. In both host local authorities not all staff in front-line positions were qualified, and therefore entitled to be called social workers; sometimes these staff were referred to as *care managers*. The front-line staff were managed by what are typically called *team managers* who are responsible for a small team (typically 6-10 staff) with an element of delegated responsibility for resource allocation and for ensuring practice standards. In the thesis I have used the

title *service manager* to refer to a range of roles that oversee the team managers and provide senior operational management responsibility for service delivery and resource allocation.

The study refers to *commissioners* as the local authority function that specifies and manages the delivery of care. The commissioning role is developing from a primarily procurement function on behalf of a local authority to one where it manages the social care market to ensure adequate supply for the needs of the community. Implicit in this is the need to ensure that there is sufficient capacity to meet the needs of people funding their own care or those funded by other public sector organisations including the NHS. The services are delivered by *providers* who are a mixed economy of local authority organisations, elements of the NHS and, primarily, the independent and voluntary service sectors.

There are a number of terms specific to the delivery of personalised care that will appear in the study. Historically the term Individual Budget was used by In Control (a charity that undertook much of the early development work on personalisation) to describe resources for social care services. In the subsequent policy guidance, and much recent literature, the resources allocated to the individual to contribute to their support for their social care needs are referred to as a *Personal Budget*. Where this is combined with other resources, such as to meet housing or employment needs, this becomes an *Individual Budget*. In this thesis the later definitions of Personal and Individual Budgets are used. Some practitioners refer to *self-directed support*, which were the underlying principles of self-assessment and independent brokerage set out in Transforming Social Care (Department of

Health, 2008), initially proposed by In Control. The payment of cash to an individual to meet their assess needs became an option in 1996 and is referred to as a *Direct Payment*.

In looking at the decision making around the use of social care resources it is inevitable that the concept of eligibility for services is considered. In the study the assessment of *eligibility* is based on either the criteria used in Fair Access to Care Services (Department of Health, 2002) or its successor the National Eligibility Criteria that were set out in the Care Act and its attendant guidance and regulations. The definition of *care* (or *care and support* in the Care Act 2014) is used to indicate a wide range of tasks to support another person. Where this care is related to the physical assistance of an individual, such as eating and drinking, toileting, washing or dressing, this is defined as *personal care* in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Typically, UK legislation is referred to by its title and year of Royal Assent. As substantial reference is to be made to the *Care Act 2014* the year is omitted to aid readability.

CHAPTER 2. BACKGROUND AND CONTEXT

The introduction of the NHS and Community Care Act 1990 saw adult social care in England being increasingly commoditised by the actions of local authorities, who together are responsible for purchasing about 55% of the social care delivered each year to people in their own homes (Wanless, 2006). Although the public sector has a dominant purchasing power, much of the care provision continues to be either purchased by individuals or provided at no cost by the estimated 5.7 million family members and friends providing informal care in England (Buckner & Yeandle, 2015).

As the policy behind the commissioning of care changed to focus on delivering a personalised model of support, there was the expectation that there would be a substantial change in the approach to commissioning services. Where care management recognised and encouraged the role of informal support, personalisation went further and sought to empower the individual as a citizen to take control. The individual was to be able to use all their available resources, including social capital, in order to innovate and create support that better met individual needs and environment. The question was therefore how much influence have families and friends had over how the care was commissioned and delivered, and what on-going care and support they could be expected to offer

Based on the work of social capital theorists, particularly Putnam (2000) and Coleman (1988), the intention of the study was to look at whether social capital was present and whether it was being mobilised to deliver more than the daily tasks that constituted informal care, such as supporting innovation in

the use of personal and state resources. In assessing the impact of social capital the second question was whether there was a difference in the social capital of people with a learning disability and of older adults that might account for the higher cost of services provided to the first group.

The first cohort of the study involved interviews with people using services in two local authorities and showed that, whilst the participants had social capital, it was not being consistently mobilised to enhance their care and support. Having gathered some data about the background to this from the first cohort, a second cohort (local government staff) were interviewed to try to understand, from the local government perspective, why social capital was not being mobilised and how the implementation of personalisation was affected. During the research the national adoption of financial austerity started to have an impact on adult social care, which, along with the implementation of the Care Act, has started to change the way that local authority staff in particular view their role.

Whilst the original focus of this thesis was on the impact of social capital on personalisation, the response from the first cohort's interviews indicated a need to step back and review the experience of policy implementation and the changing environment in which social care found itself, in order to better understand what was being reported.

In this chapter there follows a description of the range of services that were being commissioned by local authorities and the overall structure of the care market that personalisation sought to develop. This will briefly look at the role of informal care in the commissioning process and the development of direct

payments in order to understand the role social capital may have in the ongoing implementation of personalisation.

Recent history of social care in England

The development of the delivery of adult social care

The introduction of the NHS and Community Care Act 1990 was seen as a critical phase in the resource allocation of social care. Before 1993 services for people in need of state-provided support were arranged by a member of staff, who was then responsible for delivering the service. Many local authorities developed substantial residential and domiciliary care services, as an alternative to long stay hospital services, which were allocated to individuals by the managers of the services (Rummery & Glendenning, 1999). The resources were limited and demand tended to be managed by reallocation of resources within fixed departmental budgets, rather than commissioning according to the needs of the individual (Means, et al., 2008). The result was a mix of waiting for a service in some areas and overprovision in others depending on local priorities and capacity.

The exception to this was that residential and nursing care was funded through the means tested welfare benefits system, with the only limit being that eligibility for nursing home care was based on need as assessed by local health workers, who had no responsibility for the ensuing expenditure. As a result there was a higher than anticipated number of care home placements for the population (Wanless, 2006). As a result of the increasing costs of care home places, change was required:

As various commentators have argued (Means and Smith, 1994; Lewis and Glennerster, 1996), the government would not have developed its community care policies were it not for the pressing need to control expenditure from the social security budget on people in independent sector residential and nursing home care. (Lymbery, 1998, p. 870)

In addition to the changes required to manage resources there were additional drivers being promoted by the New Right and, conversely, the developing social work agenda. A discussion on the role of New Public Management is covered in Chapter 3 and the challenges this presented with its scepticism of the role of professional groups in the public sector.

The NHS and Community Care Act 1990 and subsequent reforms

The NHS&CC Act resulted in a separation of the commissioning and provision of care and the marketisation of services (Means, et al., 2008). Social work services in social care remained part of the commissioning function and were responsible for the assessment of individual need and the allocation of resources. The ambition was for a user led approach with the guidance focussed on empowerment.

‘Arguably, even those authorities that sought to implement the changes in a user-centred way still tended to an approach that set out to make things better for users rather than empowering them.’ (Lewis & Glennerster, 1996, p. 198)

At the point of implementation Lewis & Glennerster set out the challenges in implementation with some authorities embracing the new ethos and others being reluctant. Later commentators including Means et al (2008) and Glasby and Littlechild (2016) set out evidence that a common approach to empowerment and user-led services had not been achieved. As such,

commentators like Duffy (2008) noted that the resource allocation continued to be controlled by professionals within local government; the 'professional gift' approach to service commissioning. The person receiving the service had little say in who came to support them and how the service was arranged.

The NHS&CC Act required that local authorities met the demands for services as they arose, with the expectation that many services would be commissioned from the independent sector thereby creating an ostensibly market based (consumerist) model. Lymbery described this as a deliberate ideological approach:

The legislation has introduced some key aspects of New Right theory into the welfare state, including a belief in the greater economy, efficiency and effectiveness of private sector management; consumerism; the virtues of competition and the benefits of a social care market; and a deep mistrust of public service professions and their claims to special knowledge and expertise (Abbott and Wallace, 1990; Kelly, 1991; Lawson, 1993). (Lymbery, 1998, pp. 869-870)

In summary Lymbery noted that:

The service- related objectives of the White Paper should be seen in the context both of the financial imperatives outlined above, and of the ideological preference for independent sector care. (Lymbery, 1998, p. 870)

Demand was managed by the use of eligibility criteria, with each council being able to adjust this in line with available resources. It was expected that this would encourage alternatives to residential care and reduce the overall demand on the state resources for residential care that were transferred to local authorities. It was this procedural approach that was set out in the

guidance that was recognised as creating a tension with the aim of empowering people as it was inherently a top-down implementation.

‘The guidance set out the changes as a series of logical steps, but any mechanistic approach to them, in the sense of going through the motions of setting up new structures and functions without a firm idea as to how these would come together, was unlikely to result in significant change.’ (Lewis & Glennerster, 1996, p. 199)

The duty to provide Best Value services in the Local Government Act 1999, and increasing demand within limited budgets, forced local authorities to review their delivery structures resulting in a rapid reduction of directly provided services in favour of those commissioned from external sources. The 2014-15 statistical bulletin showed that expenditure on in-house homecare was 6.2% of the gross total expenditure on social care (Health and Social Care Information Centre, 2015). The language of local authorities started to be that of commissioning, contracted services and managing markets (aspects of a consumerist model) rather than direct provision. This was in line with the New Public Management outlined by Hood (1991) that brought together managerialism and a view of institutional economics that included a reliance on principal agent theory (see p 52). In social care this was known as care management; a set of processes that defined and co-ordinated the provision of care within a legal and performance management framework.

The care management process was a cycle that involved six sequential stages in managing and delivering care (fig 2.1). The approach is similar to many quality cycles found in industry as it describes the entry to support through assessment and then the allocation of resources leading to

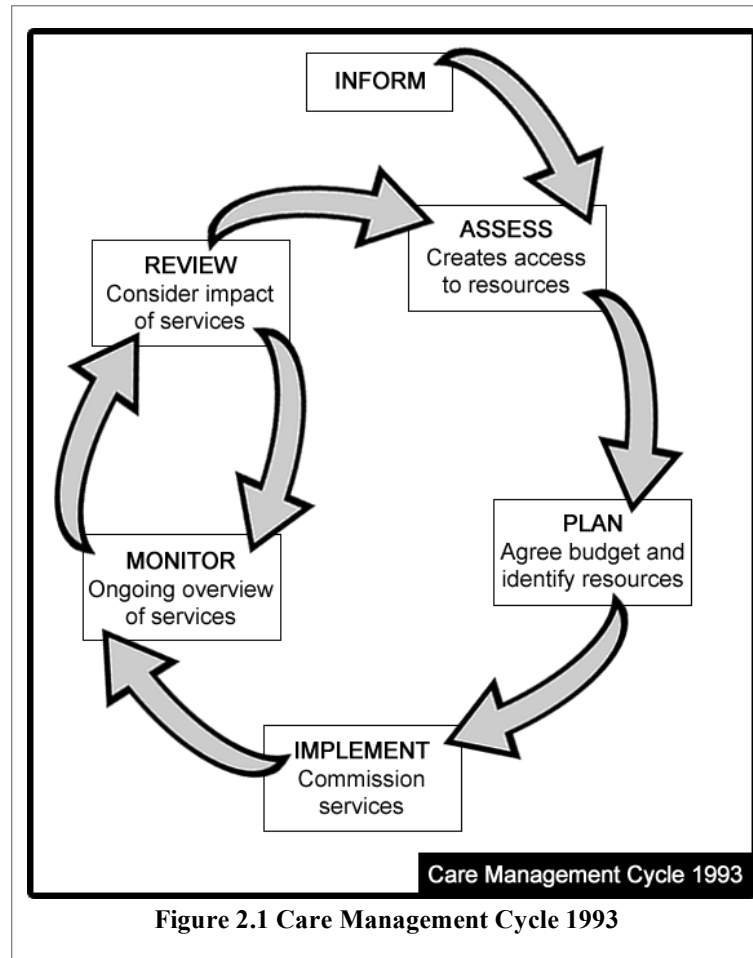


Figure 2.1 Care Management Cycle 1993

the periodic review of their impact. As care management developed it became increasingly bureaucratised with tasks being divided between teams.

‘With different staff responsible for each stage of the process [...] there was a perception amongst practitioners, as well as users and carers, of a discontinuous or episodic process rather than one that is coordinated, integrated and continuous.’ (Means, et al., 2008, p. 64)

Whilst described as a service that manages support there is also a risk that, in seeing it as a set of individual tasks, it can appear more like a set of discrete products that in turn fails to meet public expectations of a public service (Osborne, et al., 2012).

Whilst the initial pilots were called case management and focussed on support for individuals, the final guidance introduced care management:

The ostensible reasons for this were the claim that it was a range of care services that was actually being managed, as opposed to individual cases, added to the supposedly less stigmatizing nature of the term care management. (Lymbery, 1998, p. 871)

This seems particularly prescient given the later commentary from the interviews about the importance practitioners were giving to their role managing resources rather than offering individual support.

Although the initial guidance behind the NHS&CC Act placed an expectation on social workers to include carers in the assessment the reality advanced by carers was that this was not consistent, resulting in the Carers (Recognition of Services) Act 1995. This placed a duty on local authorities to assess carers independently from the person they were caring for. It took the provisions of the Care Act to create equivalent frameworks for assessment and eligibility for both those in need and their carers. The reality advanced in practice is that supporting carers is complex and is a role for the social worker working with the individual and their network rather than two discrete activities.

Service design and models of care

In 1993 the approach to service delivery was based on a limited number of models. For older adults, personal care was offered through domiciliary carers, day centres and residential homes (some with nursing care included). Some social support was also provided by sheltered housing schemes with visiting or resident wardens (Means, et al., 2008).

Whilst many people with a learning disability lived in family homes the primary service options were based around day care, residential care and, in discrete areas of the country, some supported living or even long stay NHS services (predominantly ward based care) (Means, et al., 2008).

Access to these services depended on the source of funding with most state resources delivered through local government (adult social care departments) although some funding from the NHS was available (e.g. continuing health care or old long stay funds) (Rummery & Glendenning, 1999).

Since then the options for older adults have increased with the development of short term interventions focussed on rehabilitation and re-ablement and alternatives to residential care (Glendenning, et al., 2010). Some extra-care housing (individual accommodation with a care team on site 24 hours a day) has been created in many areas, along with the more recent appearance of 'village' communities that offer a range of different care choices within a single service. All these options have tended to result in larger institutions to realise economies of scale, although they are often sub-divided into individual units to make them more accessible to individuals. The implication is that whilst there has been innovation to meet the expectations older people have of owning their own home, this has been delivered without public funds and without necessarily changing the underlying model of care.

For people with learning disabilities the options have changed, with a programme of reducing institutional day services in favour of more personalised services based around community resources and employment, as set out in the *Valuing People* White Paper (Department of Health, 2001).

There has been an increase in people having their own homes, with support from domiciliary services (supported living), although living with families remains a significant means of support for about 40% of people. In line with the aim of the second white paper, *Valuing People Now* (Department of Health, 2009), NHS residential services had all but ceased by 2011 with the completion of the closure of campus type services. Whilst the guidance that accompanied the closure programme encouraged innovation in the form of supported accommodation, it did not see the end of all institutional care funded by the NHS for a much smaller number of people. Use of these residential services continues to be controversial after the failure of independent sector (Winterbourne View) and public sector (Southern Healthcare NHS Trust) services.

Following on from the two white papers, local authorities have sought to involve people with learning disabilities in service planning at a strategic level, but there is limited evidence that this has resulted in fundamental changes or innovations in the way that care is delivered; the power over services remaining with managers and professionals (Means, et al., 2008).

Delivering Support

Informal care

Historically informal care from family and friends has been an essential part of social care with social networks being expected to pick up caring roles when the state was not prepared to do so. Consideration of the role of social networks in developing our current approach to support was included in the discussion of the role of the community in providing care that was taking place

in the 1960's (Means, et al., 2008). The same authors also note that the 1989 White Paper Caring for People recognised the reality that 'the great bulk of community care is provided by family, friends and neighbours' (p.75). In these discussions was the recognition that, following the war, social networks were not providing the same support, with society becoming more dispersed, a discussion that was picked up by the social capital theorists like Putnam (1995).

Whilst it is easy to identify the different types of care that are paid for by the state and those that use it, local information on the support from families and friends is not as easy to identify. Often referred to as informal support, there are over 2 million people in the UK receiving support as a result of age or disability (Foster & Fender, 2013), whilst Carers UK have used the same Office for National Statistics data to identify 5.7million carers by including those offering 0-19 hours support per week (Buckner & Yeandle, 2015). Analysis of survey information reported that informal carers tended to provide less personal care (toileting, washing and dressing) in favour of maintenance tasks such as cleaning, laundry and shopping (Foster & Fender, 2013). This was supported in the 2015 report from Carers UK which showed a consistent increase in the number of carers and the level of support being offered.

Whilst Carers UK suggested that the value of all informal care in 2015 was £132 billion per annum (Buckner & Yeandle, 2015), the ONS, using an approach linked to likely eligibility for social care, estimated in 2010 that informal care should be valued at £61.7 billion (Foster & Fender, 2013). Wanless (2006) took the number of carers responding to the 2001 census and compared this to the number receiving support from local authorities and

reported that about 10% of those carers that were eligible for support came forward with a claim.

The value of informal carers is significant, both financially and emotionally, to the well-being of many people needing support. Initially legislation (such as the Carers Act 1995 and the Carers (Equal Opportunities) Act 2004) sought to recognise the need to support carers, but did not place a duty on local authorities to meet assessed needs.

The definition of social capital (see Chapter 3) would include the practical support received by the person from immediate informal carers, as well as those in the person's wider social network. However social capital may also appear in a wider sense through the provision of peer support that imparts knowledge and advice on how to relate to authority organisations and their representatives. This goes beyond the information captured in the UK through surveys such as the Census and the General Household Survey.

The approach to eligibility in the Care Act places informal care ahead of state funded support, meaning that local authorities are only asked to fund support when social networks are not able to meet the need. As informal care is of such greater community value, compared to the provision of paid for care, it is essential that this informal support is utilised effectively and innovatively if the state is to avoid having to pick up the costs when it is withdrawn.

Direct payments for care

The development of direct payments (where people are given money by local government in order to purchase their own care) is well charted by Glasby

and Littlechild (2016). First made possible in 1996 the policy intention was to create a mechanism by which an individual can take control of the resources made available for their care. This was expected to lead to a greater flexibility in service model and innovation in delivery. Originally implemented for people under 65, from 2000 it was extended to those over 65.

Whilst individuals perceived a continued reduction in support from local authorities, councils reported that gross spend on social care continued to rise implying that the number of people needing support was increasing faster than the allocation of resources. With resources being constrained, the idea of the individual taking over the commissioning of their own care, so they could prioritise what mattered to them, was promoted by individuals (see Leadbeater (2004)) and groups such as In Control (Duffy, 2008). At the front-line Ellis (2007) was observing that practitioners were faced with inadequate training, procedures and resources resulting in rationing behaviours described by Lipsky as typical of street-level bureaucracies (Lipsky, 1980). Along with a lack of capacity to support individuals in terms of providing information to help with managing finances, Ellis (2007) proposed that this would limit the uptake of direct payments.

By 2015 expenditure on Direct Payments had reached 46% of spend on community based services. The table (2.2) shows that whilst significant numbers of direct payments were made for younger adults, it was still struggling to make an impact with older adults.

	Homecare £,000	Direct payments £,000	Direct Payments %
18-65	297,390	1,004,358	77
65+	1,291,833	361,968	22
All ages	1,589,223	1,366,326	46

Table 2.2 Expenditure on Homecare and Direct Payments
(Health and Social Care Information Centre, 2015)

The policy environment

The introduction of personalisation

A more detailed review of personalisation occurs in Chapter 4, this description is intended to set out the policy environment. The introduction of the NHS & Community Care Act brought in the concept of person-centred services that were based on the needs assessment of the individual.

There is an underpinning assumption that the needs and resources of each person will differ, and that the social worker must therefore develop an individualized response to each person. (Lymbery, 1998, p. 867)

As noted above, Local Authorities were required to develop local resources in a mixed economy to give individuals choice in how they were supported and by whom. However Ellis describes how the behaviours of practitioners continued to limit options as they sought to manage public resources that were not keeping up with demand (Ellis, 2007).

In developing the approach to personalisation there was a strong emphasis on placing the citizen, or their representative, at the centre of planning and delivering care (Department of Health, 2007). To manage the decision making around the allocation of resources local authorities were encouraged to develop Resource Allocation Systems that linked eligible needs to specific contributions towards care, although the final budget remained subject to means testing (ADASS, 2010). This was to be managed through personal budgets that gave people a choice between taking a direct payment or asking the local authority to commission all or part of their care (Means, et al., 2008). Beyond a short term transformation grant, no new money was to be made

available, indeed the expectation was that giving control to individuals would realise increased efficiencies in resource use (Department of Health, 2008).

Comparing the development of personalisation and the implementation of Community Care (especially care management) there are a lot of parallels in the interface with the citizen; accounting for individual needs, developing user-led services, strengths based planning, all within an environment of reducing resources as demand is increasing and significant organisational change. The main difference seems to be the role of the front-line practitioner which has changed from that of a co-ordinator (the care manager) to that of a facilitator (the traditional social worker) in the Care Act.

The implementation of personalisation has occurred against a background of a national austerity programme. Based on a survey in 2014/5 the Association of Directors of Adult Social Services indicated that in real terms there had been a reduction in resources for social care of 26% since 2010 (Jackson, 2015). At the same time the primary tool used to manage the demand for resources, the eligibility criteria, had been replaced by the National Eligibility Criteria from the Care Act. At a time when most of the money for adult social care came from local taxation, the ongoing restrictions on councils' abilities to increase council tax revenue meant that they could not increase resources in line with demand (National Audit Office, 2014). Some additional resources were made available from the NHS through local Better Care Fund arrangements commencing in 2014, although these came with defined benefits to be realised (Webster, 2015).

Austerity and the development of the Care Act

This study was designed in 2011 during the early phase of the period of austerity following the 2007 financial crash. At this point the savings in local government were significant, but had a small impact on adult social care. According to the National Audit Office the reduction in social care in 2011 contributed about 15% of the total reductions in local government spend, whilst by 2014/15 it had become 40%. At the same time there was an increase in the number of requests for support, whilst the number of people being supported fell (National Audit Office, 2015). The Association of Directors of Adult Social Services in March 2015 noted this reduction and said that, whilst they had avoided reducing the quality of services provided, it was likely that this would not be maintained. The planned expenditure to 2020 was showing no reduction in the pressure on social care. (The Health Foundation, 2015)

It was against this backdrop that the White Paper, *Caring for our Future*, was published in 2012 (Department of Health, 2012). Informed by the Law Commission report on the legal framework relating to adult social care and the Royal Commission on the funding of care, this was the government's response to its view of the way forward. Whilst some of the details resulted in debate, the overall approach had multi-party support and the Care and Support Bill was published in 2012. The Care Bill superseded this in 2013, with the Care Act receiving the Royal Assent in May 2014. Of interest to this study was the focus on the delivery of person centred support, putting the individual in control of their own services and putting the rights of carers on the same footing as the person being supported.

These changes had a significant impact on the environment in which the study took place and had to be considered in the findings. Whilst austerity in particular takes no specific account of social capital, social capital has an impact on the resources available to the individual and how they are able to maximise them.

The challenges of the Care Act

In her critique of personalisation West voiced her concern that personalisation, implemented during the period of austerity, could become ‘the neo-liberal end of state-sponsored care and welfare’ (West, 2012, p. 655). This was drawn from a study that looked at the competing pressures of the policy of austerity, the ambitions of personalisation and the difficulties seen in a council whose policy implementation was formally challenged. The subsequent Care Act tried to answer some of the challenges West’s study considered as the Act set out a legal vision for what personalisation was to mean.

The philosophy of the Care Act saw a significant departure from the past; whilst previous legislation had been a development of the state welfare agenda based on the Poor Law, as described by Glasby and Littlechild (2016), the Care Act started from an agenda that considered the person needing support to be a participant in the process (Department of Health, 2016). It had a vision of presenting the consumer with a range of information about possible services, some of which would be rated in the same way that hospitality services are, supporting them with a finance package, where necessary, and then giving people scope to configure and purchase support

as they believe it fits their needs. This concept requires a significant culture change in the provision of public services, from supporting passive service-users to guiding consumers. Ferguson (2007) reflected on Beresford and Croft's description of this top-down, individualistic, approach as being consumerist in nature contrasting it with a bottom-up democratic model based on empowerment and social justice and how this linked to Leadbeater's description of personalisation. It was something that Beresford returned to later when asking if personalisation was democratic or consumerist/managerialist in nature (Beresford, 2009). If the consumerist model were to dominate, the focus of the front-line professional changes from the provision and management of state resources to that of a facilitator and advisor.

Concluding observations

Social care has developed significantly in the last thirty years in the way that it is commissioned and delivered. The NHS&CC Act 1989 set out a vision of empowerment and needs led services, yet the structural and procedural guidance that accompanied its implementation compromised this ambition, with its emphasis on the procurement of services by public bodies, leading to many examples of services being professionally defined and allocated. The voice of the user has been weak in the process, although this is starting to change. Part of the challenge to this is that whilst the services for those with the highest needs are allocated and controlled by professionals working in a market economy, the potential to change this is limited. For the user of services to increase their say in the services they receive, they need to

influence commissioners who have the ability to manage provision, or have a direct input into the market, and make decisions for themselves as to the services to be supported.

As care management is transformed to personalisation it will require a stronger voice for the individual, within a bottom-up approach, that empowers them to believe that they can make decisions that impact on services. The use of direct payments could in theory provide a framework to avoid the risk averse culture around public procurement, although there will be a challenge in providing assurance to local authorities that they are meeting their responsibility to efficiently procure services.

One of the principles of personalisation is the view that the individual is usually best placed to direct their own care arrangements, if necessary with the support of their natural network. This is seen by social capital theorists as a component of social capital, where the individual draws on their own resources in order to manage their environment. However, the risk is that in giving the individual control over the allocation of resources, both public and personal, will it be possible for local authorities to continue to manage within available resources. For West the concern is that to deliver on personalisation there is a need to meet public expectations which are likely to preclude significant reductions in individual allocations (West, 2012).

The national programme of austerity has reduced the available resources for social care, so local authority managers have had to exercise a tight control of budgets in order to meet all their responsibilities. The study was intended to consider an aspect of the implementation of the policy of personalisation, and

therefore makes a contribution to the discussion as to whether the implementation of these two different policies can be undertaken simultaneously.

In looking at the cost of care and the allocation of resources there needs to be an understanding of the role of social capital in micro-commissioning, and therefore the contribution it can be assigned in the macro or strategic commissioning debate. In this way it mirrors the earlier debate amongst social capital theorists as to whether social capital is based at individual, organisational or community levels. The next chapter will seek to understand the approaches to social capital that can inform social work practice.

CHAPTER 3. LITERATURE REVIEW

When looking at the impact of social capital on the personalisation of social care the topic divided itself into two areas of literature; social capital and related economic concepts, and policy implementation.

This review considers the development of ideas around social capital, in particular the work of Putnam, Coleman and Bourdieu, followed by more recent work that looked at its relevance in the UK and tried to identify how to ascribe a value to it. Social capital has strong links to behavioural economics, so there is a brief summary of economic concepts that are used in the findings and conclusions. The question from the literature around social capital that the study expects to explore are whether social capital exists for those that seek support from local authorities, and if an impact can be ascribed to it that supports strategic service planning.

The review of the literature on the development of policy implementation looks at the work of Lipsky on the concept of street-level bureaucracy (Weatherley and Lipsky 1977; Lipsky 1980) and the recent discussion of this amongst social work academics in the UK. This is seen not only in terms of the experience of social care services and their users, but also with an acknowledgement that it has to be seen within the context of public sector austerity and the discourse of the New Public Management.

As this is looking at the behaviour of both managers and front-line practitioners, the literature points in the direction of the discussion around street level bureaucrats. In social work literature the debate about the role of street-level bureaucracy has been centred on the service eligibility decision

(Evans, 2011; Ellis, 2007) or safeguarding (Ash, 2013) rather than the development of the resulting care provision.

Search Methodology

The initial literature review was undertaken in a traditional manner, identifying core texts, particularly through the library, and then following back themes of interest. Of particular note was the book by Field (2008) that introduced the initial social capital theorists and led to Fine (2001) and Lin (2001). These then led to searches in journals for articles that cited these key writers and the key discourses. An early edition of the book by Glasby and Littlechild (2016) was equally influential in developing the work on personalisation, although the *British Journal of Social Work* also turned out to be influential in introducing Ferguson (2007) and Ellis (2007) in the same volume. This informed the development of the methodology of the study and the initial interview schedules.

Following the interviews with the second cohort of participants the literature was reviewed and a wider approach taken to place the findings in a theoretical perspective, as suggested by Eisenhardt (1989) in her work on using case studies. Appendix 5 has a list of most of the search terms used since December 2015 in Google or Google Scholar to support this thesis. Use has also been made of on-line repositories such as Researchgate and iza.org to access papers that have either been removed by publishers or are in the process of being peer reviewed. This brought in recent literature on social capital and personalisation, but also led to consideration of aspects of policy

implementation (particularly street-level bureaucracy) and the implementation of austerity in the UK.

Social capital

The literature around social capital recognises that elements of it have persisted since the writings of Durkheim in 1933 when he discussed the social networks around individuals. In the early 1960's economists created the concept of human capital to describe the value of a worker in society (Becker 1964 in Becker, 1993). This looked at the individual and what that person was worth to the workforce. Social capital appeared as a specific term in academic literature from about 1988 with key definitions from Coleman (1988) and Putnam (1995). In demonstrating the subsequent rate of development further reference can be made to Field (2008, p. 5 Table 1), which shows that citations referring to social capital increased from 2 in 1991 to 429 in 2006. What this is demonstrating is that the concepts behind social capital have been considered by social science writers for at least a century, but that the work bringing it together as a concept has been a more recent phenomenon. It can be set out in three phases starting with the social capital theorists (including Coleman, Bourdieu and Putnam) that set out the theoretical parameters for social capital, a second group that looked at its relationship with other academic disciplines (see Lin and Fine) and then a wider group that have been looking at how social capital theory can develop our understanding of our interactions with groups and then, in return, be supported as a citizen. For example, in 1999 the World Bank started to look at the role of social capital at family and community levels, in terms of its value in economic terms, based on the original framework of social capital (Bartkus & Davis,

2009, p. 11) whilst others have started looking at its application in social media (Steinfeld, et al., 2008).

In this section I will look at the development of thinking around social capital since Coleman, review the position taken by economists to understand the value of social capital and to then consider how much can be said at an individual level of the impact of social capital. Inevitably I will be maintaining a critical awareness that much of the writing is based on research undertaken in the United States. There has been research undertaken in the UK that showed that, although the overall frameworks are similar, the underlying conclusions about the existence and quality of social capital are not transferrable between countries (Hall, 1999). This was a question that Putnam himself posed at the end of his seminal article *Bowling Alone* (1995).

Descriptions of social capital

‘Inescapably, social capital is a cascade of perverse oppositions.’
(Fine, 2001, p. 191)

Theories around social capital have developed from three different strands of thinking: sociology (Durkheim and then Putnam), cultural systems (Bourdieu), and economics (Coleman). The link is that they all saw that in communities individuals sought to create networks to establish their role and from this to extract benefits (Lin, 1999). However the caution that Putnam in particular articulated was that in his studies in America this social capital was declining (Putnam, 1995). Later work went on to look at social capital in different systemic roles such as health care and health prevention. In each case the definition of social capital had to be set out by the author against which the

research was evaluated. This led Ostrom to comment 'A multitude of definitions exist.' (Bartkus & Davis, 2009, p. 17).

There are various descriptions of social capital based on the background of the author. Those with an economics background start with a description based on the idea that capital implies a profit on a transaction (not just a reciprocal return), linked to the idea of generating wealth through interactions, and that in this context it is profit from social interactions (Lin, 2001). From this it is possible to see how the original commentators such as James Coleman saw links to the human capital theories of Becker (Coleman, 1988). Schultz and Becker saw human capital as being a tool by which economists could assess the value of a workers contribution (Becker, 1993).

Bourdieu identified three forms of capital, economic, cultural and social that together define the individuals place in society. In his view social capital was the resource that has been recognised to have been developed in the relationship between the individual and their social networks and engagement with voluntary organisations. In this definition Bourdieu makes it clear that the recognition must be mutual, an organisation that does not recognise the individual or vice versa would not contribute to social capital (Siisiainen, 2003). Predominantly based at an individual level, Bourdieu did see social capital as having a role in groups and social classes within a community. It is noted that Bourdieu saw the link between social capital and economic capital, 'economic capital is at the root of all capital' (Field, 2008, p. 18). However as this is taken from a Marxist discourse he saw that there was a negative aspect of social capital, as withholding it can perpetuate inequalities – what Ostrom and Davis (Bartkus & Davis, 2009) refer to as the dark side of social capital.

Coleman saw social capital as being a development of rational choice theory, that we are all motivated by our own interests to co-operate in society and that society itself is an aggregate of many individual choices (Coleman, 1988). As such whilst social capital is a product of the individual's relationships, it can also be viewed as a community resource. Whilst Field (2008) described Coleman's approach as 'controversial', Fine was more direct in challenging the empirical evidence behind Coleman's conclusions (Fine, 2001, pp. 65-81). In particular, there was the question as to whether the economists can appropriately aggregate individual choices into a market response, yet Coleman recognised that in empirical terms their approach has borne fruit. As Coleman was studying educational performance his conclusions tended towards the family level rather than specifically the individual. The collaboration between Coleman and Becker was important not only for the theoretical constructs, but because Coleman moved thinking about social capital away from psychology and cultural networks towards that of economics and the way that the individual relates to communities and wider society (Fine, 2001).

In his *Foundations of Social Theory* Coleman set out six elements of social capital:

- Obligations and expectations,
- Information potential,
- Norms and effective sanctions,
- Authority relations,
- Appropriable social organisations, and
- Intentional organisations. (Dynes, 2002, p. 4)

This took social capital beyond the consideration of social networks and the trust and norms that give them value. Coleman recognised that for networks

to have a value to the individual or their family they needed to be based on a set of agreed behaviours and offer an element of reciprocity (obligations and expectations). From an economist's perspective this concept of gain through a transaction was essential in supporting the use of the term capital, that Putnam had not included in his definition. I return to this discussion in the next section.

'capital is seen as a social asset by virtue of the actors' connections and access to resources in the network or group of which they are members.' (Lin, 2001, p. 19)

Coleman recognised that, as with any asset, social capital needed to be developed and maintained by an agreed set of expectations understood by both agents as well as appropriate responses if these were not upheld (norms and effective sanctions). Where Bourdieu saw social capital as being potentially ephemeral, that it was neither permanent nor transferrable, Coleman recognised the framework within which this occurs.

When studying access to education Coleman recognised the value of knowledge in informing choice (information potential). This he proposed was one of the gains offered by social capital, that well networked parents had access to knowledge about schools and the admissions system so they were able to make better choices for their children (Coleman, 1988). Linked to this is another externally focussed ability, the ability to manage relations with authority figures and organisations (authority relations). Bourdieu noted that through social capital people and groups were able to achieve more than their resources would have anticipated. Coleman proposed that social capital offered access to decision makers that would not normally be available to the

individual and an awareness of the appropriate approach most likely to be successful. In this thesis, the elements of social capital relating to the provision and sharing of information and managing authority relationships are considered to be essential contributions of social capital to the planning of care delivery.

More difficult is the inclusion of organisations in the definition. Coleman recognised that some community organisations were created in order to support individuals with a specific interest or need (intentional organisations) whilst others did so as an extension or development of their original purpose (appropriable social organisations). In England there is a wide variety of community organisations supporting people with social care, many of which would not be within the remit of social capital in that there is no reciprocal aspect to the social network. Creating a definitive distinction of organisational contribution towards social capital is one of the areas of difficulty in applying these definitions. It is therefore helpful to look at Putnam's work before returning to this subject.

Putnam defined social capital as the 'connections among individuals – social networks and the norms of reciprocity and trustworthiness that arise from them.'. The difference between social capital and a more general 'civic virtue' was that it was 'embedded in a dense network of reciprocal social relations' (Putnam, 2000, p. 19). This leads us to a key aspect of this study as it requires a consideration not only of the presence of social relations, but also an understanding of their reciprocity and value. A social relation that does not offer the potential to generate added benefit cannot be considered as part of the individual's social capital. Putnam described relationships as formed of

bonding ties (close familial type networks) and bridging ties (weak links between groups or individuals with a common interest), which each have their role in shaping the experience of the individual. In defining the need for reciprocity in social networks, Putnam has created a significant test for the presence of social capital. What he did not do was define the value or type of exchange required, leaving it up to the individual. For this study, looking at social care, the exchange may not be overt, but should be identifiable by both parties as being a transaction linked to known social ties.

Trying to resolve the approaches of Bourdieu and Putnam, Carpiano came up with a set of criteria against which he was to assess health outcomes. He re-phrased Putnam's ideas as being social cohesion – the ties and networks that lead to social capital, but which in themselves only act as an intermediary stage. Carpiano (2006) proposes that social capital is based on the networks that link to the neighbourhood. The approach is posited on Bourdieu's work looking at neighbourhoods in the post-war period.

Continuing the tradition of Portes (1998) in trying to resolve the different aspects of social capital, Rostila concluded that

'social capital is composed of three components—social networks, social trust and social resources. Yet, the two former components are considered as preconditions for the formation of the latter (social resources). Social capital hence comprises the 'social resources that evolve in accessible social networks or social structures characterized by mutual trust.' (2011, p. 14)

Trying to resolve the different definitions of social capital Fine (2001) represented social capital as a range of characteristics by excluding other forms of human and economic capital with the remnant being social capital.

This definition by exception is interesting in that it recognises that a classical economic model breaks down when at the level of the individual, yet as an analytical tool it is hard to realise into a framework that can be tested. His conclusions however are worth noting in the context of this study:

‘On the one hand, it is self-help and cooperation raised from the individual to the communal level at some tier or another. On the other hand, it is the rich and powerful speculating on how to improve the lot of the poor through prompting their self-help and organisation without questioning the sources of their economic disadvantage.’ (Fine, 2001, p. 191)

The capital in social capital

One of the regular discussions when defining social capital is the role of capital. Commentators like Bourdieu start the discussion with the description of capital as being a resource that can be accumulated by an individual. Sobel notes: ‘Bourdieu does not propose an investigation of social capital using economic methodology, but his definition of social capital fits easily into strategic models of economic behavior.’ (Sobel, 2002, p. 139).

However, the nature of social capital is difficult to relate to in traditional economic terms. Ostrom notes that for an economist the ability of an individual to create social capital requires the use of reciprocating networks and interactions, but does not use a physical resource to create a specific asset. The economic concept of human capital starts to offer a similar challenge in that some economic services are based solely on knowledge or activity that does not relate to a defined physical output, but whose outputs are valued and can be quantified. However social capital has no ‘additive unit’ with which it can be valued and compared. Further, the use of social capital

can result in its depletion as economists would expect, but it can also result in its extension. 'By careful use of your relationships and networks in a way that is trusted and respected by others you can increase the value of the network.' (Bartkus & Davis, 2009, p. 22)

Fine suggests that 'there is no problem in principle in measuring social capital as long as it is quantifiable in some form or other'. (Fine, 2001, p. 179) However, the ability to attach an economic effect to social capital remains a problem in evaluation. Fine goes on to look at whether ranking and aggregating social networks can give a proxy measure for social capital, but this, he recognises, does not give any value to each link and whether they are an asset (Fine, 2001, p. 181). This starts to make evaluating the gain for the individual from social capital very difficult, although, when aggregated to a community level, this may be possible.

Individuals and communities

Again, starting with Coleman (1988) it is interesting to reflect on his view of society being made up of individuals making their own choices (rational choice theory), which, when aggregated, created a social order. Fine (2001) notes that, as economists were focussed on individual exchanges that built up a neo-classical model (described as social exchange theory), they were slow in taking up the idea of rational choice until Coleman incorporated it into social capital theory. Later Fine talks about the emergence of neo-capitalist thinking, something that is essentially based on a model of individual action aggregated up to community level – in the case of social capital similar concepts.

Looking at social capital as an aggregate allows economists to view it as a resource that can be quantified for the community, even if the impact for the individual cannot be measured. Glaeser et al. (2002) sought to develop a model in which social capital is considered as a complementary resource to human capital. From this analysis there are a number of conclusions that have an impact on this study. They note that over time social capital will reduce either as a result of age or isolation from the source of that social capital (its investment). Secondly, that there was a direct link between individual social capital and the levels of interpersonal contact, and allied to that that it reduces over physical distance

Looking at the value of social capital Sobel wrote that 'Individual choice can to some extent determine the strength and extent of connections, although not all of these connections are subject to choice' (2002, p. 139). This further emphasises the point above, that the key decision point is with the individual which policy needs to recognise to be effective.

Ethical aspects of social capital

Whilst the focus on social capital has been on the positive aspects that engagement with networks can bring, from the beginning there has been a recognition that there is a negative aspect. Portes (1998, p. 5) described how Bourdieu spoke of the role that social networks can have in isolating minority groups from accessing the benefits of social capital, either by directly excluding them from being part of the social network or, indirectly, by enhancing access to the key social benefits to those linked to effective networks (thereby maintaining privilege).

On the negative side, social capital can restrict individual opportunities and freedoms or result in excessive claims and obligations being placed on a person. Who you know may tip the scales balancing the positive and negative consequences of social integration (Mirowsky and Ross, 2003), but social factors, such as gender, age, or socioeconomic status (SES), can affect who you have an opportunity to know and the types of benefits that might accrue through those connections. (Moore, et al., 2009, p. 1071)

Whilst Putnam was interested in the community gains from social capital he did recognise that some chose to identify with groups that were seen to have a negative view of society and create a social capital that did not benefit the wider society (2000, pp. 350-363). This Uribe demonstrated as he explored the way that corruption became embedded in organisations and communities (2014).

In recognising that social capital played a number of roles, Ayios et al (2014) sought to address it through the use of different ethical perspectives. These sought to take the different perspectives of social capital (including the Neo-capitalist approach favoured by policy makers in the UK and the Network model common in social work practice) using the ethical models including Utilitarianism and Ethic of Care (see table 3.1, below). In putting together this analysis they sought to challenge 'that social capital [...] is either value-neutral or, simply put, a force for good.' (Ayios, et al., 2014).

As the following sections of this chapter look at the application of social capital in social care in England, the strands Ayios et al identify are a useful framework to describe the different perceptions of social capital, particularly those of neo-capitalist and developmental origins. When looking later at the

development of social capital in policy implementation around social care it is helpful to note the Kantian view of the developmental strand in the table.

Table 1: Summary of the application of ethical theory to four traditions of social capital

Social capital as	Ethical theories	Justice	Kantianism	Ethic of Care
Traditions of social capital	Utilitarianism Close alignment between neo-capital theory and utilitarianism. Social capital is seen as providing collective social goods and aggregate welfare.	Subjugation of the needs of some in order to achieve the greater good results in distributive justice concerns. Particular concerns where it is the most disadvantaged who pay the price for the advantaged.	Individuals identified as forms of capital rather than being afforded individual respect as persons.	No account taken of relationships, rather an assumption of people as rational, economic individuals which runs counter to an ethic of care.
Network/ Reputation	The perspective of the greater good is dominant but not necessarily commensurate with the pursuit of individual goals.	Closed networks may create 'in' and 'out' groups and be a forum for coercion and inequality by social exclusion. This is a more commonly acknowledged 'dark side' of social capital in terms of bridging and bonding.	Instrumentalisation of social relations and reputation – using others as a means to an end. Goes against Kant's universalisability imperative by promoting favouritism and nepotism.	Undermines the value of genuine relationships and promotes relationships built for personal gain which are contrary to an ethic of care, except where in doing so close personal relationships benefit. Complex analysis needed of the resistance, for example of the poor, to enter into relationships which will create obligations.
Neo-Tocquevillianism	Utilitarian claims by the powerful to meet their goals subjugate the needs of the less powerful.	Responsibility for social inclusion shifted onto the excluded. State abdicates welfare responsibilities to individuals, communities and NGOs. Imposition of preferred norms goes against liberty and free will of individuals.	Fundamental aspect of Kantianism, demonstrating that respect for persons is violated.	Protecting those with whom there is a relationship could be in keeping with an ethic of care.
Development	Assumption of optimum returns by promoting social capital 'creation'.	Enabling more equitable societies and protection for the least well off is commensurate with a justice-based approach.	Individuals should be allowed to formulate their own rationally arrived at choices, not guided by a pre-established development agenda.	Feelings of empathy and concern for others embraced, but at the cost of the rights of individuals and elitism. Instrumentalisation of relationships is inappropriate according to an ethic of care.

Table 3.1 Summary of the application of ethical theory to four traditions of social capital (Ayios, et al., 2014)

Social capital and local services in England

Since the work by local authorities on Transforming Adult Social Care (Department of Health, 2007) commenced, discussion papers have begun to use the term *social capital* when considering the role of social networks. The discussion has focussed on the role of community groups and their contribution, in particular, to the agendas of prevention and information provision. Whilst these may fit Coleman's description of intentional or appropriable organisations, to be included as social capital they need to evidence that they have reciprocal bridging ties to the individuals being supported. The groups need to demonstrate that they offer more than just being funded by the state to meet centrally defined goals. Many of these initiatives are better described as being evidence of the creation of community capital, the capacity of the community to support its vulnerable members (Miller & Whitehead, 2015), without the commensurate link to personal investment and access that defines social capital.

One of the key aspects of social capital is that, whilst it is often considered as an aggregated, community, resource it is nevertheless the result of individual investments in networks that they will derive benefit from in the future. It is not a resource that can be given to the individual as a result of state action. An example of this state led approach to social capital is found in Knapp:

Developing social capital through projects that build community capacity has the potential to benefit the community at large, as well as providing personal benefits for the individuals, recipients and providers involved in such initiatives. (Knapp, et al., 2010, p. 3)

Whilst some of these projects may fall within Coleman's definition of intentional organisations, the majority do not. Knapp based his work on Muir, in Camden, which looked at social capital in a council area (recognised as multiple geographic communities) from an application of Putnam's definition. Muir recognised in his consideration of the policy implications that:

'Furthermore, by its very nature, higher levels of social capital and increased participation cannot be dictated from the town hall – nevermind Whitehall.' (Muir, 2006, p. 20)

Where central and local government seek to develop projects that specifically aim to develop social capital (the developmental perspective, p50) the indication is that community resources and community capital may be achieved, but there is no established link from that to an increase in social capital experienced by the individual. When considering the resources available to the individual Gillespie and Duffy (2008) relied on a description of community capacity that embraced aspects of social capital along with what is now recognised as community capital. As these developmental projects are top-down initiatives (as will be defined later in the policy implementation literature) the question has to be whether there is an alternative bottom-up approach that would be more effective.

Human capital and social capital

Following on from the discussion about the role of community organisations in creating social capital it is worth reflecting on the personal dimension. Coleman's early work involved significant collaboration with the economist, Becker. Becker put forward the proposition that individuals have a range of skills, experiences and knowledge that they accumulate which he called

human capital (Becker, 1993). These are unique to the individual but are part of the resources the individual offers to benefit the overall community, be that through employment, study or community activity.

Coleman (1988) identified that through the interactions between individuals there was a synergy created that he called social capital. This was a gain to the participants that went beyond what they might have been able to do in isolation.

Social Entrepreneurship

The actions of social entrepreneurs and the enterprises they create enhance cooperative norms within a nation, providing positive signals about caring for others through working to support societal objectives and group needs. (Estrin, et al., 2013, p. 2)

As noted in the Background chapter social capital theory was being disseminated alongside the development of personalisation. During this period the definition of social capital used in the personalisation literature was starting to incorporate aspects of community capital, as defined in Gillespie and Duffy (2008), and social entrepreneurship (Estrin, et al., 2013).

In considering the development of the social entrepreneur Estrin et al proposed that the social entrepreneur may have a contribution in developing social capital, particularly in relation to Putnam's bridging ties, through the weaker links between groups (Estrin, et al., 2013). What is more consistent with their vision is that social entrepreneurship develops community capacity, and potentially community capital, with social capital only being one aspect of the whole. It is this social entrepreneurship activity that more closely describes the vision in recent policy documents about stimulating community

resources to meet some social care needs. However, it is noted that the focus of the development of community capital has been on prevention and wellbeing services (Miller & Whitehead, 2015), rather than the remit of those needing higher (eligible) levels of care. Social entrepreneurs are essential to the development of intentional organisations, such as user-led groups, that Muir (2006) recognised as being the focus for local authority capacity building that could lead to an increase in bridging social capital.

Reviewing the literature one of the distinctions between the effect of social capital and social entrepreneurship is the way that it is seen to operate. Social capital is based on the property of relationships that have developed over time, it is essentially a reactive property that is developed over time and based on individual interactions. Social entrepreneurship is an active process linked to social needs and seeks to create community capacity to support individuals. What is not always clear in social entrepreneurship is the reciprocal nature of the support to allow it to be defined as social capital (Bourdieu and Coleman) rather than the wider community capital. Social capital has been seen to incrementally reduce over time and distance, meaning it needs to be maintained, but does not usually disappear immediately. With social entrepreneurship the risk is that it depends on the entrepreneur and may not be sustainable once that driving force is removed.

Understanding the impact of social capital

In this thesis the approach of Putnam will be used to identify the presence of social capital, by identifying the existence of social networks, whether there is reciprocity in them and that they are being maintained in a way that allows

individuals to trust the support they offer. However, this does not lead us into an understanding of the impact that social capital has on the planning and delivery of care, let alone its wider effect on the life of the individual.

To understand the impact of social capital it is proposed that Coleman's six elements (see p39) are used as they define aspects of social capital that can be covered in an interview. This would give a good indication as to whether social capital is being mobilised to improve the support to the individual and, potentially, whether this has an impact on the way that services are personalised.

In looking at the role of social capital Putnam recognised that ties were of different strengths and nature. This will have an impact on the social capital available to individuals, with bonding ties offering the most resource. It was planned that Coleman's information potential and authority relations elements would be particularly tested through questions about innovation and creativity that are central to personalisation and were not seen as core to the care management approach to service delivery.

Together Putnam and Coleman's approaches to social capital enable the researcher to analyse the behaviours that block the identification and mobilisation of social capital. To access social capital there needs to be a good understanding of individual social networks, the obligations and expectations on which they are built, the way that individuals are supported to understand their options and how to achieve the results they seek. This is a complex social construct that challenges the proceduralist approach of care management, but one that staff are expected to manage.

With the changes in how we access our social networks, due to ICT and enhanced travel opportunities, there is a greater potential for previously neglected social capital to be accessed. This does not appear to have been recognised in literature to date as it modifies previous social capital studies showing access to resources depleting over time and distance. This could be a new approach to delivering the reinforcement Lin identifies with social capital (Lin, 1999).

Economics and behavioural economics

The development of social capital was based on the links between economics (Coleman), sociology/politics (Putnam) and psychology (Lin). It is therefore worth looking at what we can learn from economics discourses to enable understanding of the models that describe people's behaviour. In this section the economic foundations that are relevant to the research findings are set out.

Economic models give a simplification of the 'question' and are designed to give a better understanding and explanation of various aspects of the economy. They are logically constructed and assume that those involved behave in a rational way (Antonioni & Flynn, 2011). In considering the economic approach to welfare Becker describes rational choice as:

'The analysis assumes that individuals maximize welfare as they conceive it, whether they be selfish, altruistic, loyal, spiteful, or masochistic.' (Becker, 1993, p. 386)

Coleman saw the individual decision to access social capital as a rational choice to improve their position in society. Whilst Field is concerned about the

focus of rational choice theory on the individual, not the political, economic and social structure in which the individual is placed, he does note that:

‘Rational choice theory lends itself to the economic analysis of social capital, with its attention to questions of investment and returns.’ (Field, 2008, p. 161)

Behavioural economics uses insights from psychology and sociology to better understand human behaviour; it develops the economics discourse by factoring in how real people behave in the real world. ‘Neoclassical economists have long assumed that human beings are making rational choices in their own interest. Behavioural economics undercuts these assumptions to reveal how we really are.’ (New Economics Foundation, 2016).

In analysing the way that decisions are made, commentators in behavioural economics have studied the context in which they are framed (Kahneman, 2003). Whilst conventional economics assumes that rational decision making is independent of the many influences in a situation, behavioural economists have recognised that the way in which a decision is framed can impact on the decision made, that not all decisions are wholly rational. This bounded rationality is not only linked to the person’s capacity to analyse the situation, but also the ability to bring together and assimilate sufficient and available information. This limitation in terms of framing and the provision of information makes it possible for a third party to manipulate or bias the person’s decision making.

Having recognised the potential that a third party can influence a decision, Sunstein and Thaler (2009) went on to describe that role as being a choice architect. The choice architect is not only the person that sets out a range of options that influence the final decision, but also the person that guides the identification of specific information through designing a form of computerised data set. Through a range of indirect framing activities, the choice architect is steering the individual to a single or set of decisions in line with their personal or organisational agenda.

Looking at the models of policy implementation (next section), the top-down approach uses a discourse more akin to traditional economics (using hierarchies and principal-agent models) whilst later approaches appear to be influenced by behavioural models.

The assumption in personalisation is that the consumer is able to act as a rational actor in seeking to make the best use of the range of resources available to them, an application of rational choice theory (Becker, 1993). However, the vast majority of individuals will have been party to the institutional approach to service delivery that will frame their response to decisions (Bowles, 1998). In looking at social choices Taylor-Gooby (2008) recognises that it is more complex than that, as individuals also bring to bear their own values and experiences. He notes that there are strong co-reciprocating pressures that will modify decisions. This is reinforced by the social environment of the individual.

‘Forward-looking behavior, however, may still be rooted in the past, for the past can exert a long shadow on attitudes and values.’ (Becker, 1993, p. 386)

An example of this might be a group of parents looking to commission services for young adults when a day centre is to close. The rational actor approach would be to look for alternative resources on an individual basis, but often what happens is that the group works together to identify possible solutions, although that may involve individual compromises.

The local authority is expected to adopt a substantial role as a shaper of local markets (Department of Health, 2016), using its financial position and community influence as a choice architect, but the advent of personal budgets will need to see a change in the way that this influence is used. It has been noted by economists that people tend to consume the familiar rather than necessarily adopt the most efficient means of meeting their needs. Bowles (1998) sets this as the market framing the choice of the consumer, with a consideration that, if this is also promoted by local authorities, the effect is likely to be strong enough to remain after the initial framing ceases. This is a key discussion in framing the understanding of developments in the delivery of services.

The basic assumption in the arrangement of personalised care is that the individual will be able to issue a contract to a supplier for the provision of support, the first level of incentive theory.

‘we consider the principal-agent model where the principal delegates an action to a single agent through the take-it-or-leave-it offer of a contract.’ (Laffont & Martimort, 2009, p. 15)

In making the delegation there are assumptions about the understanding of the principal as to what is being delegated and how the contract should be fulfilled. This implies a level of potential information asymmetry, particularly if

the agent is the better informed. This emphasises the importance in social care of ensuring that the individual is supported in this delegation, either through their access to social capital (Coleman's information potential), their own human capital or from a state engaged actor (a social worker or third sector advisor). Laffont and Martimort (2009) go on to detail the complexities of contracting with multiple agents, but assume that there is a single mind in the form of the principal.

The use of principal agent theory in the public sector indicated three parties to the process; two principals (the population and government) and agents (Lane, 2013). Whilst the population as a whole could be seen to have a set of cultural norms (Coleman, 1988), there is no requirement that the 2% that use social care services in England (Health and Social Care Information Centre, 2014) will necessarily have the same values when choosing their own social care services. This creates the potential for a dichotomy between the expectations of the overall community as to what care should be provided and the community of people actually accessing care and support. By placing the user of services, that is the disabled person, at the centre of the decision about service use this is potentially creating a third principal. In traditional economic terms this is creating a complex principal arrangement that leaves the agent unclear as to who they should be responding to.

The concept of social and market norms has been of interest to behavioural economists such as Clark and Mills since 1979 (Clark & Mills, 2011) , as it seeks to understand the different responses to essentially similar propositions. Summarising their work, Ariely suggests:

'The social norms include the friendly requests that people make of one another...Social norms are wrapped up in our social nature and our need for community.' (Ariely, 2008, p. 1055)

The market norm is the active engagement of commercial interests:

'The second world, the one governed by market norms is very different. There's nothing warm and fuzzy about it. The exchanges are sharp-edged: wages, prices, rents, interest, and costs-and-benefits.' (Ariely, 2008, p. 1071)

The argument he goes on to make is that each in itself has a role, the problems arise when an actor reaches across from one set of behaviours to the other.

In the case of social care, the neighbour that does the weekly shopping, alongside their own, is doing this as a social norm, consistent with Coleman's concept of obligations and expectations. Whilst it is acceptable to offer an insignificant gift in appreciation, that is one whose value is not comparable to the value of the task, the point at which the participants seek to determine a value for the transaction, financially or otherwise, it becomes a market norm. Where the individual is acting according to social norms it is an action essentially within the concept of social capital, whereas a market norm is not. Portes (1998) reports that it was Bourdieu that first proposed that it was the role of social capital that differentiated between social and market exchanges.

What behavioural economics is indicating is that the transformation required to support personalisation will need to go further than setting out new procedures and performance management frameworks for professionals. With current user expertise being based on care management and challenging the choice architects there will be a need to disseminate information that will help

develop a new set of expectations based on individual empowerment and a different approach to the commissioning of support. Within an environment that places significant control in the hands of professionals and paid carers, and a society that tends towards a patronising approach to people in need of support, what behavioural economics is showing is how hard it is going to be to make individual empowerment a reality. Whilst few people have any real experience of personalised services there remain few drivers towards a new framing of care delivery. However, it is expected that users of services will be familiar with the consumerist model, the reality of market and social exchanges and the value of social capital, what appears to be needed is the permission or support to apply this to the commissioning of care and support as a new framing expectation.

Policy Implementation

The study was undertaken at a time when government was implementing both the personalisation of care and a policy of austerity, so it is worth considering the key messages from the policy implementation literature that relate to social care. In the study there were many comments from participants about the approach taken to the implementation of personalisation and the aspiration of creating transformation and innovation in social care. This was focused on the front-line behaviours reported by participants, although it has its roots in the way that central government and local authorities approach policy implementation.

This section starts with a discussion about the approach of front-line workers in social care, which Evans (2011) and Ellis (2007) reflect back with Lipsky

(2010) on his earlier work on street-level bureaucracy. It is followed by looking at existing links to personalisation, before taking a wider look at policy implementation. The section concludes with an overview of the rise of managerialism and then recent policy implementation commentaries from the UK.

Street-Level Bureaucracy

Based on observations of public service delivery in the USA during the 1970's Lipsky developed the concept of a street-level bureaucrat. This was a role in which the individual was placed in a front-line position where they were expected to make allocative decisions on behalf of local government in order to further the aims of political, usually national, policy objectives (Lipsky, 2010). What Lipsky describes is an organisational culture in which managers seek to deliver policy through setting standards and then monitoring performance against them, whilst the front line staff seek to meet a range of conflicting organisational, social and personal motivations in deciding how to best deliver the public services they represent. In the later edition Lipsky notes that many street-level bureaucrats are also responding to a professional agenda that further modifies their approach to policy as workers seek to reconcile the macro level policy intentions with the reality of decisions they have to make, using a value-base articulated through professional training and standards set by regulatory bodies. This is a new theme that did not appear in his original writing in 1980.

In the UK there have been a number of studies into street-level bureaucracy and its implications for social work (Ellis, 2007; Evans & Harris, 2004; Evans,

2011) although many authors have since reflected on this. In developing the argument there is a need to establish that the definition developed by Lipsky is relevant, such as:

- the ability of the professional to exercise discretion (Evans & Harris, 2004; Ellis, 2011),
- that they worked in financially challenged environments (Dunleavy, et al., 2011), and
- that policy was being developed that had an element of ambiguity (Ellis, 2011; Needham, 2011).

Lipsky observed a number of motivations for the behaviours of street-level bureaucrats, which he modified in 2010 to take into account the increased prevalence of professional specialization in the public sector (Lipsky, 2010). Front-line staff needed to be in a position where they had to make rationing decisions (regarding time, money or information) and exercised an element of control over the environment in which this was happening. Secondly, front-line staff developed routines and processes to manage the role that they could use to justify the approach and decisions that resulted. Finally, street-level bureaucrats have a strong value base to which they refer, that informs decision making. Within professional staff teams this tends to be a professional code rather than an organizational one. It is not unsurprising then that since the 1980s social workers in England have not only adopted a professional code, but they have also readily engaged with professional registration.

Following the introduction of the NHS &CC Act a series of changes happened in social care that increased managerialism and sought to reduce the discretion of front-line practitioners (Evans, 2011). The development of the New Public Management (Hood, 1991) brought two key challenges to social care. The first was the inherent skepticism that NPM had around the professional agendas in play, and the second was the performance management agenda linked to the specification of roles and the definition of tasks as either service commissioning or service provision. Ellis (2011) describes the research and discussion about the impact this had on workers discretion, reaching the conclusion that front-line workers retained their power as gatekeepers and the core party that negotiates with the individual on behalf of the state over their access to social care.

Lipsky (2010) himself noted that a major factor at play in the creation of the street-level bureaucrat was that managers had limited ability to direct the intervention between the worker and the citizen, and no more than when it came to scrutinising the appropriateness of the resulting resource decision. The discussion in Ellis (2011) indicates that she believes that this continues to be the case in England; that the increasing rigour of managerialism and performance management has moved the place of the negotiation, but has not significantly circumscribed it. Evans goes further and states:

‘while managerialism within adult social services has sought to contain professionalism, it has not eliminated it; nor has it sought to do so.’ (Evans, 2011, p. 372)

Indeed Evans (2011) notes that the increasing burden of guidance, local rules, case law and professional regulation have made it harder to remove the ambiguity that Lipsky identified as a founding condition in his work.

Whilst Lipsky gives a definitive description of the street-level bureaucrat as a front-line worker, Evans (2011) was challenging the purity of that concept in that his study provided evidence that front-line managers in social care shared the professional values and expectations of the social workers, even though it may have been in conflict with the managerial perspective of the organisation. This may in part explain why the continued promotion of top-down, performance management approaches have failed to create the environment for top-down policy implementation that would have been expected.

When considering the implementation of the NHS&CC Act, Lewis and Glennerster (1996) noted the different approaches to implementation in different authorities. This apparent demonstration of discretion by local politicians and senior managers has been described by Evans:

Senior managers cannot simply be understood as perfect policy servants in their role as policy implementers; their motives and concerns need to be acknowledged to understand the impact and role of their discretion on policy and its implementation. (Evans, 2016, p. 613)

Whilst Lipsky (1980) initially saw front-line practitioners as using discretion to modify policy implementation, in his later edition (2010) he recognised that in many organisations senior managers may also exercise discretion that framed policy implementation and therefore the environment in which front-line practitioners exercised. It was no longer considered appropriate to assume

that senior managers were the direct tool for policy makers, who would implement policy without comment.

Street-level bureaucracy and e-government

The introduction of ICT has resulted in government bodies increasingly using web sites and electronic portals to support the delivery of services. Whilst the focus of this study is on the interactions between people, the increasing use of ICT to provide information and to record resource allocation cannot be ignored as it will change the way that Coleman's information potential is realised, as well as its impact on the role of the front-line worker seeking to control information and exercise discretion in decision making.

In their initial work on the impact of ICT, Bovens and Zouridis (2002) described the path where street-level bureaucracies transformed through screen-level bureaucracies to a system-level solution. The first stage was where ICT became the key recording tool which controlled the way that information was collected and managed.

'Public servants can no longer freely take to the streets, they are always connected to the organisation by the computer. Client data must be filled in with the help of fixed templates in electronic forms.' (Bovens & Zouridis, 2002, p. 177)

The system-level bureaucracy is described as being the point at which the organisation becomes fully automated and all decisions are made without reference to the individual. The focus of the public servant becomes one of maintaining and developing processes and, where necessary, supporting the public to use the system. At this point the discretion of the street-level bureaucrat has been lost.

A recent paper (Buffat, 2015), looking back at this work, recognised that the initial position put forward by Boven and Zouridis, that ICT curtailed the discretion of street-level bureaucrats, was too simple. They pointed out studies that suggested that ICT offered a more nuanced position and that in some situations ICT enabled front-line workers to use it as an active resource to support citizens.

Buffat highlights Boven and Zouridis' own comment that the curtailment approach is unlikely to be successful in public services that require interaction with citizens, as is typical of social care. The analysis indicates that prescribed approaches to assessments and then using an algorithm to allocate resources is unlikely to be satisfactory, a scenario that was tried (self-assessments followed by the use of a Resource Allocation System) in social care and then necessarily compromised through implementation.

In expounding the enablement thesis Buffat recognises that front-line professionals respond to ICT by seeking ways to enhance its value as a tool. In setting out discretion as a requirement for street-level bureaucracy Lipsky leaves open a range of different ways in which it is exercised. What the enablement thesis describes are the ways that decision making changes with the introduction of ICT, and, as managers receive more quantitative information, they tend to lose the qualitative aspects on which performance management depends.

Street-level bureaucracy and personalisation

From the literature, the current discourse is that front-line workers, probably with tacit management support and an increase in the definition of the

expectations of the professional role, continue to act as street-level bureaucrats in terms of the implementation of policy as it is seen in terms of the allocation of resources at the point of assessment. This has significant implications for the implementation of a top-down policy, in this case personalisation, which is dependent on the interaction between the front-line worker and the citizen in need of support. In reviewing her work on street-level bureaucracy Ellis noted:

‘The advent of personalisation raises fresh questions about the nature and scope of frontline discretion in social care as those forces which proved significant in previous studies are once again reconfigured through computerized resource allocation systems; a resurgence in traditional social work skills and tasks; and the potentially empowering impact of self-assessment and individualized budgets.’ (Ellis, 2011, p. 240)

The review of personalisation (Chapter 4) will establish that the initial ambition of that policy was to place the citizen at the centre of the planning and delivery of support. This could be a challenge to the established approach of street-level bureaucracy as it moves the decision making away from the professional. However there are aspects such as the control of resources remaining with councils, and the expectation that social workers will be facilitators and information givers (Department of Health, 2016), rather than gatekeepers, which will further complicate the view as to how the role will change.

What has not been explored is how the actions of the street-level bureaucrats in social care then affect the development of care packages to deliver the assessed support, and whether social capital is being mobilized as part of this process. As already discussed this is in part due to the move from care

management to personalised support as the focus has advanced from assessing needs and determining eligibility to one of assessing eligibility and then allocating resources for support.

Development of policy implementation theory

Recent reviews of the development of policy implementation theories (Saetren 2005; Paudel 2009) have cited deLeon & deLeon (2002) and Barrett (2004) for their reviews of the development of learning to date.

The first generation of policy implementation studies is often noted as coming together through the works of Jeffrey Pressman and Aaron Wildavsky (1973) in their book '*Implementation*'. Based on a case study approach the authors came up with some basic principles for implementing policy, describing:

- Clear channels for programme execution
- Avoid plans involving multiple stakeholders with differing motivations
- Deliver initiation and implementation through a common set of actors.

Overall their view of policy implementation was of a central body in an organisation developing a policy idea and then acting through a hierarchy to see it delivered (Pressman & Wildavsky, 1973). Writing later Barrett (2004) noted that policy studies at the time tended to focus on deriving good policy, assuming that implementation was a rational response that would follow on.

This led to the second generation of research in which researchers took two differing positions. deLeon and deLeon (2002) described how some researchers sought to develop an empirical theoretical base, which could describe the most effective way of developing an idea and then efficiently delivering it through public organisations, known as the top-downers. For

these researchers it was the implementation that was of interest more than the subject itself.

The alternative position adopted saw policy making as a continuum in which the original policy was negotiated between actors during implementation resulting in the final policy being a modification of the original. Barrett describes the bottom-up camp as being 'associated with those espousing a micro-political view of intra- and inter-organizational behaviour,' (2004, p. 255) in which researchers analyzed the motives and actors involved with policy implementation.

Finally a third generation of models started to appear that sought to bring forward elements of previous generations by looking at hierarchies and structures whilst also looking through the lenses of power and negotiation (Barrett, 2004). This offered the opportunity to explore the complexity of public policy implementation (deLeon & deLeon, 2002).

The study of policy implementation had its peak in the 1980's and early 1990's. The debate was very polarized and some commentators have suggested that that in itself caused people to look elsewhere (Saetren, 2005). However this fails to recognize the common strand that was also picked up by deLeon and deLeon (2002) and Barrett (2004) that recognized that neither top-down nor bottom-up approaches were in themselves a satisfactory explanation and as such offered limited rewards to those researching policy implementation.

Criticism of both strands of policy implementation include the difficulty in identifying a single 'controlling mind' that is able to articulate clearly the intended policy such that all actors can sign up to it (deLeon & deLeon, 2002).

The development of managerialism

The 1990's saw the emergence of the managerially led, top-down organizational cultures in the public sector that would explain Barrett's proposal that:

'In this new policy construction there was perhaps less perceived need for studies of implementation since there was a belief that the 'reforms' in the public services associated with the New Public Management had addressed the key problems of 'implementation failure' which include a lack of clear unambiguous policy objectives, resource availability and control over implementing agencies.' (Barrett, 2004, p. 258)

In essence, policy implementation had become a management task and as such competed for time and resources along with other organizational demands. This takes us back to the negative culture Lipsky (1980) described, where the public servant either seeks to manage resources for the individual in front of them or more likely places themselves away from the decision making process and distances themselves from their professional role.

Whilst the New Public Management was to become the dominant discourse for the public sector in the UK during the late 1990's and 2000's, it is interesting to look at recent commentaries on the model. Osbourne, Radnor and Nasi (2012) have written an article in which they challenge the relevance of the NPM model, initially as it was based on concepts relevant to commercial markets that were focused on delivering a manufactured product

and secondly because as a model it is unable to manage the demands of the public who are not interested in the detail of multi-party public service systems. They recognize the new paradigm as being one in which actors manage inter-organisational relationships and delivery systems rather than a single hierarchy, a similar construct to the models developed by the third generation of policy implementationists. The proposition of Osborne *et al.* was that most public service delivery needs to be delivered as a service to the community using service-dominant theories focused on public expectations, not by seeing them as proxies in a manufacturing system.

From this commentary there are two challenges to the delivery of personalisation. Firstly, it posits that public management theory, in viewing actions as a 'product', has created an environment where public services are 'created by professional design and input and then delivered to the user.' (Osborne, et al., 2012, p. 136) . Secondly basing NPM on manufacturing models has resulted in intra-organisational approaches being developed to deliver high levels of financially assessed efficiency at the expense of both inter-organisational effectiveness and the co-production of outcomes with service users. Both strands are being challenged by the implementation of personalisation.

Street-level bureaucracy and performance management

The introduction of the managerial approach has long been recognised as presenting a challenge to the street-level bureaucrat:

The formalising tendencies inherent in NPM thus pose a significant challenge to the SLB, enabling managers to usurp their essential discretion through increased audit and procedural

control embodied in mandatory ICT systems. (Wastell, et al., 2010, p. 313)

Tummers and Bekkers describe the challenge as:

The central role that detailed performance indicators and risk reduction rules play in the implementation process often leads to a broad variety of detailed norms and guidelines that the street-level bureaucrats involved must obey (Power 1977). (Tummers & Bekkers, 2014, p. 541)

What is being described is an environment in which the ability of the front-line practitioner is being steadily constrained by local procedures and, often more importantly, by ICT systems that are becoming increasingly complex and are taking an ever more important role in defining practice. What Tummers and Bekkers are describing is an approach where the discretion of front-line workers is curtailed over time leading to a loss in practitioners perception of effectiveness and legitimacy. Evans notes that:

Street-level practitioners, some commentators have argued, no longer have discretion because managers have created a coherent system of control through the deployment of extensive and effective systems of procedures, budgets and surveillance. (Evans, 2016, p. 602)

Wastell *et al* comment that:

there are legitimate grounds for anxiety that the imposition of bureaucratic control may have gone too far and may already have become seriously counterproductive. (Wastell, et al., 2010, p. 318)

Whilst Rowe (2012) describes the street level bureaucracy model as being ambiguous, it is neither inherently 'good' or 'bad', Wastell *et al* (2010) observe that it is the way that policy is implemented that takes on an ethical dimension governing whether front-line discretion is being used to empower or constrain

citizens. The concern is that, as performance management constrains practice, the scope for policy to empower individuals is also constrained.

Policy implementation in the UK

As noted previously the development of implementation studies in the last fifteen years has been limited. Schofield (2001) related this to the British environment, which she noted had entered into a new range of structures and actors without looking at the research into whether this was effective as a way of developing and then implementing the range of new policies then being advocated by New Labour. A subsequent search of literature related to policy implementation in the UK has shown a rich discourse around street-level bureaucracy, particularly in social care, but little that looks at other strands of implementation theory. In their conclusions, Means et al note that an implementation deficit had occurred in social care between government and the front line that was seen as being due to the 'shortcomings in the local leadership of change' (Means, et al., 2008, p. 250). However, this, they note, has not resulted in a slowing down of change rather a further drive to reach the goal set.

In their critique of New Public Management, Osborne *et al* (2012) noted that the current agenda required a new focus:

'It is now no longer possible to continue with a focus solely either upon administrative processes or upon intraorganizational management—the central preoccupations of public administration and (new) public management, respectively.' (Osborne, et al., 2012, p. 135)

This focus on administrative processes and intra-organisational management are typical of the top-down school of implementation theories, from which the inference is that policy implementation in the UK has been dominated by the top-down approach. Indeed, the Institute for Government report made the following recommendation:

‘Policy-makers should see their role more as one of ‘system stewardship’, rather than delivering outcomes through top down control: ‘ (Hallsworth & Rutter, 2011, p. 9)

Whilst the authors recognised the need to improve the approach to developing public policy within central government they did not go on to reflect on whether the available resources for implementation should be taken into account as part of the policy definition. In a subsequent report by the same organisation they stated that ‘policy design and implementation cannot and should not be separated.’ (Norris, et al., 2014, p. 13). In setting out their findings around recent policy implementations, the authors did note the need to observe impact from the front-line, but only as a tool to then adapt the approach to implementation. There was no recognition that what might be being seen were front-line workers compensating for a shortfall in the policy outcomes. This approach brings us back to Osborne et al (2012) who noted that, in the current public sector service environment, policy makers and decision makers no longer hold the tools to implement, rather they now need to steward ideas that can be implemented locally by public and private sector managers and workers.

If the literature on policy implementation is an indication of the current awareness of implementation then the message is one of central government

in England being focussed on improving its approach to policy development within the Westminster Village (Norris, et al., 2014) leading to a top-down approach to implementation through guidance, performance management and contract based governance.

The policy implementation literature indicates that, although arising from the citizenship agenda as a bottom-up initiative, once personalisation was adopted as the policy vehicle to deliver social care it was implemented in a top down approach. The implementation of personalisation has recognised the value of approaches such as co-production and citizen leadership, part of the bottom-up model, whilst leaving the power with managers within a framework of detailed guidance, performance management and tight budget allocations. Barrett (2004) writes that implementation needs to be seen through the lens of power and negotiation, which in the case of personalisation appear to have remained in the hands of managers and policy makers.

The contribution of the literature to the research question

In any research study there is a need to adopt a definition on which to base the methodology. In this study there is a need to evaluate the impact of social capital with concepts that can be readily appreciated by the participants. The definition put forward by Putnam has the advantage that it is possible to translate it into individual concepts:

“social capital” refers to features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit.’ (Putnam, 1995, p. 2)

There are particular gains in also being aware of Coleman's six elements of social capital as they start to create a framework against which the presence of social capital can be assessed.

Any study looking at the impact of social capital will need to look at the number and quality of personal interactions to assess the impact, whilst simultaneously looking to proxy measures to evaluate the value of social capital in that situation. Part of the difficulty with defining social capital is that it is not a property of the individual but rather a property of the networks and relationships that the person has developed and maintained (Lin, 1999).

This study is looking at the experience of individuals from a social science perspective rather than from an economics one. As such it is worth remembering Carpiano's comments:

' that it would be more useful to conceive of social capital in a more traditionally sociological fashion: as consisting of actual or potential resources that inhere within social networks or groups for personal benefit'. (Carpiano, 2006, p. 166)

In developing the methodology, the study needs to retain a focus on the experience of the individual and to approach the assessment of the value of social capital as that of the experience individuals have of the impact of other people, networks and communities on their care arrangements and how, as individuals, this created benefits for them in their use of their personal budget. By understanding individual narratives, the study should then seek to identify which of the experiences can be aggregated to create a commentary of what social capital might contribute to the process of care.

Previous studies have described the care management approach to social work as an example of street-level bureaucracy. The requirements of personalisation challenge this approach if people are to be able to maximize their control over their own support and mobilise their resources, including social capital. As the policy was being implemented, was there scope for individuals to draw on their social capital, in particular their access to information and understanding of managing authority, to be able to challenge the historical street-level bureaucrats in order to create the innovative and flexible support envisaged by personalisation?

CHAPTER 4. THE PERSONALISATION OF SOCIAL CARE

This chapter considers the development of the concept of personalised social care that started with Leadbeater (2004), although, as Glasby & Littlechild (2016) detail, this was an extension of previous policy development from the 19th and 20th Centuries that led to the provision of direct payments in the UK. Government reports in particular set out the aims and expected approach to implementation, although there is a developing literature around the reality of implementation.

After a quarter century of care management, the rising cost of care services, along with a social demand for greater individualisation, challenged the model of delivering care. Personalisation was seen as a key element in the transformation of social care (Department of Health, 2007) that would create a new relationship between those needing support and the wider society.

there is a need to explore options for the long term funding of the care and support system, to ensure that it is fair, sustainable and unambiguous about the respective responsibilities of the state, family and individual. (Department of Health, 2007, p. 1)

The concept of the personalisation of social care started with the recognition that many services were institutionalised and served individuals badly (Means, et al., 2008). There was a voice in the disability movement that sought to create an alternative approach that placed individuals in control of their care and support which was picked up in government policy (Department of Health, 2007). How widespread that voice was amongst those using services is not clear, but the concept of the individual designing and

controlling their own support has gained widespread recognition in the UK. Glasby and Littlechild (2016) do note that the arguments for personalisation are also supported by those with an interest in reforming social care due to a belief that the concept of the state meeting all care needs will not be affordable in the future.

This section will look at the definitions available to describe personalisation, its history and role as policy developed, a summary of how it was expected to work, and then an overview of the initial period of implementation. This will be followed by an analysis of the differences implied by the legal framework of the Care Act. Finally, it returns to the role of social capital as described through the development of policy.

Defining personalisation

A typical description of personalisation has been set out, in terms of IT services, as being: 'Personalization involves a process of gathering user-information during interaction with the user, which is then used to deliver appropriate content and services, tailor-made to the user's needs. The aim is to improve the user's experience of a service.' (Bonnet, 2001)

With experience in reporting on finance and IT it was this concept of personalisation that influenced Leadbeater's ideas on social care (Leadbeater, 2004). In his initial work Leadbeater discussed shallow and deep personalisation – do we change structures to give users more voice, but continue to control the wider opportunities available to them or do we seek to create fundamental change in our communities which result in wider common benefits. The classic example of this that he uses is the improvement in

cardiac health being caused by recent increases in the use of cholesterol lowering drugs, statins (shallow personalisation), and the long-term reduction in smoking (deep personalisation) (Ferguson, 2007). The policy concept of personalisation appeared in the White Paper, *Our Health, Our Care, Our Say*, but at no point has there been a single definition agreed for the term as it relates to social care.

In 2007 Ferguson stated that there was no commonly accepted definition in social care other than that of 'common-sense' (Ferguson, 2007). In 2008 the Social Care Institute for Excellence gave the following description:

'Personalisation means starting with the individual as a person with strengths and preferences who may have a network of support and resources, which can include family and friends. They may have their own funding sources or be eligible for state funding.' (SCIE 2008, p3)

In its 2007 protocol, *Putting People First*, the Department of Health note that it is about 'better support, more tailored to individual choices and preferences in all care settings.' (Department of Health, 2007, p. 5). This protocol brought together a range of leaders and organisations to articulate a common vision for the Transformation of Social Care, and a commitment as a leadership group to deliver it.

In Control said that 'it is primarily concerned with how to design support arrangements so they are more "personal" - which means they need to fit the person, be suitable for them.' (Duffy & Gillespie, 2009, p. 3)

Whilst there is a fair degree of congruity in the definition of personalisation used in social care, no single authoritative definition has been achieved.

Needham argues that this need not be a problem if personalisation is seen as a narrative to guide the development of service delivery (Needham, 2011). However, Leadbeater argues that without a clearly articulated vision for the change in expectations, there are unlikely to be sustainable benefits to society from personalisation (Leadbeater, 2004). Together these positions indicate that there is a risk that personalisation may not be sustainable, or, using Leadbeater's description, remains at best a shallow transformation.

History of personalisation

In describing the history of social care, commentators tend towards a commentary that describes the provision of welfare in terms of the provision of support by the state and philanthropic organisations (for example Glasby & Littlechild, 2016). This tracks the changing perception of society to welfare, leading ultimately to the split between the alleviation of poverty (known as social security) and the care of the ill and disabled (now called social care). In their review of the history of social care in the UK the authors conclude by looking at the recent development of direct payments and the moves towards personalisation.

The term 'personalisation' was first used in a social care setting by Charles Leadbeater (2004) in a pamphlet for the think-tank Demos. It was an unashamedly New Labour approach that sought to advocate the individualisation of services, personal responsibility and the transfer of risk to the citizen (Ferguson, 2007). Having defined its origins as a New Labour initiative, it did gain the support of the Coalition that followed (Needham, 2011) and then the Conservative administration.

In his commentary Leadbeater (2004) proposes that personalisation 'could be a programme to apply a lick of new paint to fading public services or it could be the harbinger of entirely new organisational logic'. The challenge he set was to make personalisation more than another top-down initiative by government agencies, but also a bottom-up response in which service users and society as a whole sought to re-organise the delivery of care. This was taken up by Glasby, supporting the extension of personal budgets and self-directed support.

'Essentially, self-directed support has the potential to transform the whole of the adult social care system by moving away from a traditional "professional gift" model (in which the state uses the money it receives from taxes to slot people into pre-paid services through the work of professional assessors and gatekeepers) to a "citizenship model" (in which the disabled person is at the centre of the process, is part of the community and organises the support they need and want).' (Glasby, 2008, p. 2)

Having started with pilots from late 2005 the initial learning was captured in an evaluation report (IBSEN, 2008). A concordat to promote personalisation was agreed in 2007 as part of the transformation of adult social care (Department of Health, 2007) and guidance sent to local authorities to support this in January 2008 (Department of Health, 2008).

The pace of change was expected to be quick, something that concerned commentators including Peter Beresford:

'But we have minimal evidence as yet of what will work best in making such change, and little more than first thoughts on how to achieve the kind and scale of change required. Nonetheless, government has committed itself to personalise services by 2011, and it expects local authorities to deliver.' (Beresford, 2009, p. 3)

With efficiency savings anticipated to offset the forthcoming demographic demands personalisation had a lot to deliver, with assumptions being made on limited evidence that this was possible.

The delivery of personalised services

The vision for the delivery of a personalised service was an approach that was inherently transparent, where the person needing support was able to understand what was being delivered, what resources were available to them and then make decisions about how they would receive support (Glasby & Littlechild, 2016). This is a significant change to the care management approach as was recognised by IBSEN:

‘They imply major changes in: organisational arrangements, processes, culture and professional roles within local authority adult social care services; in the roles of voluntary and user-led organisations; and in the expectations and responsibilities of social care service users. Conventional approaches to assessment and care management – professional-led assessments and the purchase by care managers of services on behalf of users – may no longer be appropriate.’ (IBSEN, 2008, p. 28)

Local authorities were encouraged to adopt user led assessments, including self-assessment, and to widen the range of organisations involved in contributing to an individual’s assessment, with social workers being focussed on advocacy and brokerage (Department of Health, 2008). This created a tension for local authorities as they retained the legal responsibility for meeting the needs of the individual and could not delegate the decision about the allocation of resources. (Clements & Thompson, 2011)

In the two host sites, as with most local authorities, the model adopted was that the assessment and resources allocation decision was retained through directly or indirectly commissioned services, and the brokerage function was opened up to individuals to choose either to arrange their own care, seek an independent broker or ask the local authority to undertake this on their behalf. This would then provide the support required to deploy participant's Individual Budgets (IB):

'As well as receiving an IB as a cash payment, IB holders can therefore ask their local authority care manager to purchase services for them, up to the value of the budget. Additional options for deploying an IB include payment to a third party to manage on behalf of the recipient; giving the budget to a service provider, such as a domiciliary care agency, to manage and 'calling off' services as and when needed; or management by a trust fund on behalf of the user.' (IBSEN, 2008, p. 4)

The allocation of resources within the Individual or Personal Budget was to be set by local authorities through a 'resource allocation system' (Department of Health, 2008, p. 12). Some authorities allocated costs according to what they would have spent if arranging the service themselves, others used a complex formula that took aspects of individual needs and allocated resources accordingly. These are complex calculations and not inclined towards being transparent to the service user. The legal framework underlying this was unchanged from the NHS & Community Care Act 1990 in that local authorities had to assure themselves that the resources allocated were sufficient to purchase appropriate services to meet the needs they assess (Clements & Thompson, 2011). The result was to be a new approach to delivering services, to be managed through the existing legal framework that created care management.

The implementation of personalisation

In the decade since the personalisation of social care started to be considered there have been voices for and against the approach used and whether it is possible to achieve in the current financial environment.

The research and literature prior to the adoption of personalisation was focused on the experience of direct payments and access to the national Independent Living Fund. This showed that:

‘While choice and control are important ends in themselves, the practical upshot seems to be the increased ability for people to make changes in their lives and to achieve outcomes that are meaningful to them.’ (Glasby & Littlechild, 2016, p. 119)

Particular attention was given to the gains in terms of health and wellbeing and self-confidence and motivation.

The developments around personalisation were initially a bottom-up response to the voices of people using services, and direct payments in particular (Glasby & Littlechild, 2016, p. 79). The aim was to reduce the role of bureaucratic local government structures and to create more flexible commissioning that allowed people to develop their own solution, in essence to support a range of service innovations based on the needs of the individual. In supporting the implementation In Control continued to focus on Citizenship and the role of co-production in creating self-directed support (Duffy, 2008).

This changed as personalisation was taken up by local authorities, and then government policy in Putting People First (2007) followed by the circular Transforming Social Care (2008). The paper stated that:

Driving change on the ground in a top-down Whitehall-led model is not the answer. (Department of Health, 2008, p. 9)

Yet it went on to set out a vision that was framed in terms of process, performance management and structures, typical of top-down policy implementations.

Ferguson (2007) however tempers caution in adopting what he sees as an agenda that furthers the marketisation of social care, neglects poverty, further increases the stigmatisation of welfare and has a flawed conception of the people who use social care. This is echoed by Beresford who sees the rise of a new type of service user:

‘We may even enter a new era of social care where the consumer becomes king, able to pull down a much broader and more imaginative menu of support, either directly for themselves or for those close to them - all with state aid.’ (Beresford, 2009, p. 4)

Jones (2013) notes the change in tone of official guidance in 2010 from the previous focus on citizenship and empowerment to one of freedom of choice put forward by the coalition. Glasby and Littlechild (2016) cautioned that the changing political environment could result in a shift in the support of personalisation from a rights and welfare perspective to one of individual responsibility and limited state resources. This would be a significant cultural shift in that it places the responsibility and cost of care on to the individual, although recognising that state support will be required for those that cannot afford the care they need.

What has concerned many authors have been the difficulties in embarking on a major transformational change at a time of severe budget reductions in the

UK. Whilst professional groups were positive about the future of personalisation (ADASS, 2012), even that report notes that for personalisation to be successful the care system needs to be adequately funded. By 2015 the same group was reporting that the funding had not been available (Jackson, 2015).

The legal framework for personalisation

As has previously been noted the early development of personalisation was a bottom-up response to the commentary that state funded services were not adequately meeting people's needs. This was implemented without a change in the legal framework of social care, resulting in practitioners having to compromise to deliver policy within the law (Clements & Thompson, 2011). This was changed through the Care Act which brought together legislation since 1948 into a single Act with the intention of creating a citizen-focussed approach with personalisation at its core. With its emphasis on choice, individual responsibility, personal control and the role of local authorities as market managers and a source of information and advice (Department of Health, 2016) the implementation guidance appeared to be a step towards the marketised agenda foreseen by Ferguson, Beresford and West, rather than the citizenship based approach of Duffy .

For the first time the local authority was able to delegate the decision making around eligibility to another organisation, although the terms of the legislation mean that this still remains a professionally directed activity (Department of Health, 2016, Section 18). A National Eligibility Criteria were established (*ibid*, Section 6) for the first time (previously it had been only a guide) to create a

consistent decision of eligibility for support. Whilst the allocation of resources remained a responsibility of the local authority, the means based charges made for support were set out on a national basis for the first time (*ibid*, Section 8). Transparency around the cost of care was improved by this, but the resource allocation decision remained a closed book.

The approach to the eligibility decision is of interest to this study in that the guidance set out a process that sought to ensure that the individual's own resources (financial and social) were fully explored prior to the decision about eligibility for support (*ibid*, Section 6). Where an individual need was being met prior to the assessment it would not be considered as part of the eligibility decision. This left much of the control in the assessment process with the professional making the decision. In theory this is where the front-line professional should seek to identify and maximise potential social capital in order to manage demand for state resources.

Support planning was intended to reflect previous practice in that the individual and their network are encouraged to take ownership of the plan and to maximise their networks alongside the support commissioned with local authority resources.

'Local authorities should have regard to how universal services and community- based and/or unpaid support could contribute to the factors in the plan, including support that promotes mental and emotional wellbeing and builds social connections and capital.' (Department of Health, 2016, Section 10.22)

The aim of support planning is to bring the widest range of information and choice to the individual to allow them to create a flexible plan around their needs that is responsive to their lifestyle.

'It is important that people are allowed to be very flexible to choose innovative forms of care and support' (Department of Health, 2016, Section 10.29)

This requires local authorities and practitioners to support individuals to access support either from traditional providers or other sources suitable to their needs.

'Limited lists of 'prescribed providers' that are only offered to the person on a 'take it or leave it' basis do not fit with the Government's vision of personalised care and must be avoided.' (Department of Health, 2016, Section 10.29)

There is a concern that, with the restrictions around control of resources and decisions still being made at a professional level, the approach to transformation remains weak (Henwood and Hudson in Glasby & Littlechild, 2016). By codifying personalisation through this statutory guidance it has defined the change to a top-down policy implementation, with limited scope for development in light of experience or changes in the wider economic or policy environment.

The presence of social capital in personalisation

As noted above (see p9) the literature on the dissemination of studies on the impact of social capital was almost contemporaneous with the development of personalisation. When looking at the role of social capital in personalisation it is necessary to look at how developing academic learning has been adopted in the creation of new policy.

The academic literature on personalisation makes some reference to social capital in technical papers (Office of Public Management, 2009), as do policy papers (Department of Health, 2008). In neither domain has there been a

detailed research study looking at social capital theory and applying it to personalisation, rather assuming that it is present and accessible (Duffy 2008; Office of Public Management 2009; Local Government Association 2014).

Social capital does appear in policy guidance, such as the role of family networks (bonding ties), but less account is taken of Putnam's bridging or community ties. Coleman's elements do not appear in the main, other than the consideration of information provision by local authorities, which was included in *Putting People First* (2007) and subsequent guidance. The impression given is that there is a general awareness of aspects of social capital amongst those involved in personalisation (both academics and policy makers), but there have been few specific links between the two. The OPM did a review of social capital and the delivery of social care for the DH (Office of Public Management, 2009) that led to the Building Community Capacity (BCC) project later transferred to Think Local Act Personal (2010). A review of subsequent BCC projects indicates that the focus has moved to the development of community capital, and Becker's concept of human capital, rather than developing social capital in particular.

The contribution of families and friends to support planning is noted in the statutory guidance, in addition to being informal carers, as well as being recognised by commentators. The role of social capital in the OPM review and BCC projects is centred on the delivery of support or the actions of user-led organisations in informing strategic commissioning. From a social capital perspective the resources offered would be not only in terms of the contribution in terms of tasks undertaken (informal care), but also the

information and knowledge available to create plans, manage the relationship with authorities, and potentially to facilitate innovation.

Social capital theorists would also look at the role that membership of local community organisations can play in supporting the individual. This has some recognition in the personalisation literature and policy development, but in the formal framework of the Care Act this is placed in the preventative and wellbeing section not in support planning for those with care needs. In summary, Putnam's definition of social capital can be seen in parts of the guidance, but the mobilisation of social capital using Coleman's work is not so evident.

National policy has been keen for people with experience to play a role in the strategic planning of services and the development of services delivery (Department of Health, 2006). These are recognised as a key element of informing the market management activity as they affect a wide range of people, rather than being focussed on the individual. As such this is better described as social entrepreneurship, which has had a significant impact on the development of personalisation from the very beginning.

Peer support also has a role in guiding the individual to better manage the relationship with the organisation or its representative, the authority relations that Coleman describes. This is important to the individual not only in terms of maximising the allocation of resources but also if they are looking for support in innovating or varying the model of support.

For the transformation of social care there is an assumption that much of the innovation in service delivery needed to be focussed on the individual and

their network. The role of social capital in this personalised environment is giving people knowledge about the options that might work based on experience, information on processes to access resources and the confidence to work with authorities to put it into place. This goes beyond the concept of social networks used in care management where the focus is on tasks undertaken that reduce the burden on the state. Given the perspective from behavioural economics, what is important is that local groups are supported to help frame the new model for people being offered personalised care. Without the transfer of information, and disseminating the successful experiences of those that have innovated, it is hard to see how individuals and communities will be able to change how their expectations are framed and how they can mobilise their social capital to support their care.

Social capital has already been seen to offer a route to information to support members of a network. However, it is limited by the individual's network and how it is able to assimilate changes in the model of care. Whilst it is important that information is readily available on how to commission personalised care, it is also true that networks need to be able to access this at the appropriate time.

In evaluating the impact of social capital on personalisation it will be necessary to consider not only the tasks undertaken by people that are part of the social network, but also how the individual is able to draw on other forms of support to plan, innovate and maintain service delivery that best meets their needs.

CHAPTER 5 METHODOLOGY

In this chapter I will be looking at the influences that helped design the study, how the research was undertaken and the approach to understanding the results. Initially I will be looking at the differences between qualitative and quantitative research methods to explain why a qualitative approach was taken and then go on to consider the basis for the research method chosen.

The second part of the chapter then looks at the issues around undertaking the study from the research ethics approval, the sampling approach and then the analysis of the results.

In deciding to interview people using services, and local authority staff, I was conscious that many of the participants would not be familiar with the academic language being used, although the concepts involved were likely to be more familiar. Terms like social capital were usually broken down to its elements including social networks, the support offered and its volume and reliability, how information is sought on services and how decisions about care were made (aspects derived from Coleman's elements of social capital, see p.39). In the same way it was not realistic to ask people about the impact of social care on personalisation, but it was possible to talk about their experiences planning support and how innovation in services was facilitated.

Epistemological approach

The lack of a common definition of social capital and personalisation directed the study towards a constructivist approach (Mabey & Finch-Lees, 2008, p. 49) that would contribute to the understanding of behaviours that were

important to the realisation of personalisation. This understanding was expected to emerge from the research as it drew on the shared experiences of the participants, developing an insight into the reality of social capital in developing their care arrangements. The result would be a development of propositional knowledge around the role of social capital rather than a prescriptive description of what needs to be in place to maximise its role in personalisation (Mokyr, 2002).

At the start of the study it was anticipated that, depending on the issues that emerged from the interviews with the first cohort (people using state funded social care), further investigations were likely to be required. As such, a methodology was adopted that allowed participants in cohort one to bring in their issues and thoughts and which could then be considered in a second set of interviews, to reflect back on the emergent ideas and create some understanding that could be verified.

As discussed in the literature, the background of personalisation was a user-led initiative that became a centrally driven policy. One of the tenets being put forward was that if people were to be enabled to take control of their own support they could bring their own social resources (social capital) to create a better quality service at a better cost to the public purse (Rostilla, 2011). Given the emergent nature of the subject, the intention of the study was to be consensus-orientated (Mabey & Finch-Lees, 2008, p. 80) in the way that personalisation was seen to be transforming adult social care and to develop a commentary to support future implementation.

During the study the initial findings provided some understanding of the original question, the impact of social capital, but also raised further questions about the policy implementation and the approach to service delivery in local authorities and front-line staff. As such, a more critical approach was taken in that the research was looking at what policy implementation was missing in supporting people to access and mobilise their social capital.

Having established the epistemology of the study as being essentially constructivist, the methodology follows the anti-structural paradigm in being interpretive (Hassard & Cox, 2013). As the study was evaluating part of a user focussed policy initiative, the aim was to understand the experience of those using services and develop a theoretical insight into the behaviours being observed. It was important that the approach taken was free of theoretical bias and could follow the data from the interviews. As such the indication was that a participant led approach should be preferred as it would allow issues to develop from the participants and not the researcher.

In taking an interpretive approach the methodology would be strengthened if it were to recognise the distinct populations the participants represent (Polit & Beck, 2010). Whilst often gender is a determining factor in dividing populations, due to the focus of the research the main divisions were between geographical area, type of presenting need (age or learning disability), and carer or service user. In the second cohort the main divisions were based on position within each organisation.

Qualitative approaches

A qualitative approach is commonly used in the evaluation of social capital theories and of policy reforms, as it focuses on the idea of testing out a critical theory or approach. In policy implementation its advantage is that, through using a relatively small sample, conclusions can be put forward at an earlier point than could be achieved in a quantitative study. It also makes no assumptions about the understanding of the policy subject amongst participants prior to the study. Much of the published studies developing social capital theory were based on case study approaches using qualitative (Putnam, 2000) or mixed method approaches (Coleman, 1988).

Early approaches to qualitative methods were based on a case study that sought to develop concepts that could then be tested for consistency in other environments (Glasser & Strauss, 1967; Eisenhardt, 1989). Eisenhardt took this further to set out an appropriate pathway for case study research, which starts by defining a research question, identifying cases that can demonstrate aspects of the theories in the question, and then setting out the tools and approaches used to collect data. There then follows a period of data collection and near simultaneous analysis in which the researcher engages in a reflective process and potentially changes to the sampling in order to better understand the factors at play. Finally, there is the process of developing a summary hypothesis which is then tested against other literature.

The strength of case theory building is that it is able to look more radically at a subject, capturing a bottom-up perspective and so develop a new perspective. This is particularly useful, Eisenhardt (1989) suggests, where the subject is a

new approach to the use of existing knowledge or where research to date is limited. In her conclusion Eisenhardt notes that whilst quantitative research uses data to test a theory, leading to incremental developments on existing behaviours, theory building starts with the data and draws conclusions from this. It is this theory building that supports the role of qualitative research in the evaluation of emerging public policy.

In a later publication with Graebner (2007) the same author looks back at emerging research and suggests that each case study should be looked at as a unique 'experiment' with its own analysis. This seeks to promote the rich detail that can be achieved from case studies, recognising that, the more that subjects are aggregated, there is an inevitable reduction in the uniqueness of individual phenomena.

Application of the case study approach

When considering the case study approach this study used it in an experimental manner as it sought to understand the impact of social capital alongside the policy implementation of personalisation (Ryan, et al., 2002). The role of theory in the approach used was to understand the results and to support an understanding of the issues around social capital and policy implementation.

Each participant was seen as an individual study with the interview seeking to draw out the range of their experiences around social capital. As such, each was analysed in isolation before aggregating the results as a group. This was to allow the differences between populations to become apparent before they were lost as a single entity. In this way the research sought to achieve

Eisenhardt's aim of preserving the richness of data and Yin's focus on bringing together evidence:

'A case study is an empirical enquiry that investigates a contemporary phenomenon within its real-life context using multiple sources of evidence.' (Yin, 1997, p. 13)

The second cohort of interviews was initiated as a way of developing the results of the first cohort, through the introduction of different perspectives. In this way the reliability of the conclusions was strengthened.

Quantitative approaches

Although the tradition for this type of research was to be qualitative, consideration was given to using quantitative methods in whole or in part of the study. The limited understanding participants were expected to have of the terms around social capital and personalisation would present significant methodological risks in terms of the research into social capital if a quantitative approach is to be followed. There would be an issue with the design of a reporting tool such as a questionnaire, since for participants to be able to give a consistent response to primarily closed questions it would be necessary to undertake a significant level of pre-engagement. This pre-engagement was very likely to introduce an element of bias into the responses. Whilst many could be supported through this, there would then need to be a range of questions to explore the richness of detail that needed to be separated out to understand the practice and motivation of participants around social capital. This would then lead on to a concern about the motivation and capacity of vulnerable people to participate in the study as the

questionnaires will be lengthy in either the number of questions or, if there was a move towards a discursive model, the text involved.

The issue of participation leads to the second concern which is around sample size. Based on epidemiological calculations, no more than 2260 can be expected to have a learning disability with eligible support needs in Site A and about 1600 in Site B (see Approach Used below for discussion around the choice of site). These figures were based on the rate of people known to the NHS and local authority with a learning disability (0.371% in each site, from Public Health England website) and the 2013 adult population in each site. In practice the actual numbers being supported by the local authority are usually about 20% less than the estimated number of eligible people. Survey research undertaken with service users by Surrey County Council and the NHS in Surrey in 2015 each had about a 6% return from the potential sample. This would result in anticipated returns of no more than 80-110 people in each area. With the levels of capacity and the isolation of many people with a learning disability, the actual numbers are likely to be smaller. This then becomes a small sample with high levels of error in the significance of the results. Whilst the group of older adults is larger, the ability of eligible participants to respond is less, as they rarely have access to the Internet, and will require support to send a written reply. Without a good route to access participants, the sample is again at risk of being too small for a quantitative approach.

Research tools

Following on from the epistemology, above, the methodology adopted sought to follow a participant led approach. The factors that influenced the design were:

- The lack of awareness amongst participants of what constituted social capital
- The small size of the potential sample
- The emergent nature of the social policy being considered
- The need to work directly with vulnerable adults
- The concerns that they would have around the impact on the funding they use for their care
- The risk of emotional distress amongst participants
- The uniqueness of perspectives of social capital between participants.
- The potential to construct a narrative on social capital and the implementation of personalisation.

As noted above the small sample size and the difficulty in defining a quantitative research tool meant that there needed to be a reliance on qualitative methods. A review of other similar studies showed that most used narrative or semi-structured approaches. It was also an approach that was familiar to the researcher as it had been used extensively in regulatory studies and direct work with service users. This was a good response to the need to understand the perspective of people, whose need for care meant that they were vulnerable, at a time when the changes in policy were happening so quickly.

The expectations and risks of narrative and semi-structured models were considered so as to inform the final approach adopted. Whilst a narrative approach is the preferred tool of the constructivist discourse (Hassard & Cox, 2013), the limited ability of some of the participants to independently develop their own narrative around the subjects of social capital and personalisation

meant that a semi-structured approach to interviewing was required to support participants. Consideration was also given to the opportunities offered by social network analysis.

Narrative Research

In adopting an interpretive approach to the methodology the ideal would be to adopt a narrative approach to the data collection. Squire (2013) notes that many researchers in the social sciences have used narrative approaches in the last twenty years, in a variety of different ways. Whilst there is no specific definition of narrative research models the common theme is that it is a tool to balance the power of the researcher in the relationship and an effective way of reaching into the experience of marginalised groups (Etherington, 2015).

There are a number of approaches within narrative research, which deliver against different aims. The purist model is one where the participant is given a topic and then asked to describe and reflect on it, whilst the researcher observes but does not engage. At the other end of the spectrum is the conversation in which the researcher fully participates in an open discussion that seeks to cover the issue being considered. In the open recall approach, the researcher seeks to avoid the risks around influencing the results, other than the inevitable impact of the participant being asked to consider in detail an aspect of their experience, but it is dependent on the participant being sufficiently aware of the area of investigation for them to be able to engage.

Where the models re-combine is in their use of the individual narrative to combine with others to develop insight that can start to challenge the strategic policy. This insight is not sufficiently robust in itself to challenge the current

position, but is part of the evidence on which to build an alternative proposition for further consideration. It needs to also be considered alongside established knowledge and understanding from which an argument can be drawn.

Within the history of narrative approaches is a deconstructivist element that seeks to subject language used by participants to a detailed examination (Sikes & Gale, 2006). This would be particularly helpful if you were able to identify participants with a common understanding of the research question, but differing perspectives on how it impacted on them. In this study that is not the case and as such the literature indicates that preference should be given to constructivist models such as Bruner's narrative cognition (Bruner, 1986). In this Bruner describes the final construct as being drawn from the contributions of the participants. In this approach the researcher is identifying key ideas from the narratives of the individuals and developing an overall commentary on the impact of the policy in question.

Semi-structured interviews

Having identified a narrative approach as the methodologically ideal structure for the interviews, it was apparent in initial testing that it was not going to be ideal in most situations as a result of the communication and reflective skills of the participants. It was therefore necessary to be prepared to adopt a semi-structured interview, if the need arose, that sought to maintain the constructivist paradigm (Fylan, 2005). To facilitate this, interview schedules were prepared for each research cohort that described the areas of interest

(Cohen & Crabtree, 2006) and shared with the participants prior to the start of their interview.

In both cohorts of interviews, time was taken with participants to ensure that they understood the subject and the range of questions. This was crucial to the success of the research and needed the open style of the narrative or semi-structured interview in order to understand the depth of the participant's experience. In line with the RWJF guidelines it was also considered important to conduct interviews face to face and to record them to reduce distractions (Cohen & Crabtree, 2006). The other practical advantage of the semi-structured interview was that it gave an opportunity in real time to explore ideas and concepts with participants so as to fully understand their perspective.

When analysing the data there was no specific differentiation between the narrative and semi-structured approaches, as both may feature in a single interview, but less reliance was placed on contributions that were an immediate response to input from the interviewer.

Social Network Analysis

Much of the early work on social capital used qualitative methods, in particular interviews and case studies. However by 1999 Lin was proposing a model with aspects of social network analysis being considered to map and place individual social networks (Lin, 1999) .

In reviewing the data available from this study, consideration was given to the use of social network analysis (Wasserman & Faust, 1994). Field notes that:

'To date, social capital scholars have rarely engaged with the structuralist interests of social network analysts, but recent studies seeking to map how individuals are embedded in whole networks tend to confirm that this is indeed a promising direction of travel.' (Field, 2008, p. 165)

In my study the basics of social network analysis could be identified by proposing the person using services as the primary actor, with ego-centric networks creating a self-defined boundary for each subject. Whilst some actors would have had common recipients in their relationships, their involvement was neither mutually exclusive nor would there necessarily be an impact on others from their involvement. As such the first criteria (defining the social network) is in place.

Butt notes that for social network analysis to be applied:

'we require that relations be defined on pairs of entities, and that they admit a dichotomous qualitative distinction between relationships which are present and those which are absent.'
(Butt, 2008, p. 14)

It was this need to evaluate the strengths and reciprocity between entities that had not been part of the original design and could not be evaluated from the interview data obtained. It was therefore considered inappropriate for network analysis to be added to the study.

Whilst the original design did not consider network analysis, the results of the early interviews did not indicate that this type of analysis would have changed the understanding of the behaviours that were impacting on the mobilisation of social capital. The risk in using network analysis is articulated by Field in his critique of Lin's use of rational choice theory and social network analysis:

'..This method has also been criticized for over-emphasising the role of strong ties.' (Field, 2008, p. 165)

As such the results of this study might be considered a first step towards understanding the range of networks an individual is a member of, but should not be used to then ascribe a quantitative value to these relationships, as required by social network analysis.

From the accompanying literature it was noted that in assessing the potential for the existence of social capital it was not necessary to evaluate the qualitative impact of absent relationships, only to note them.

'An individual to whom no one comes for professional advice may nevertheless have many friends, and vice versa - it is unwise to jump to the conclusion that an individual is generally socially isolated on the basis of isolation in one relation, just as it is similarly unwise to presume that an individual who is highly central in one setting is highly central in all settings.' (Butt, 2008, p. 36)

In summarising the position Butt argues that the individual is a subject of multiple networks and that a conclusion regarding their isolation or otherwise should take into account the widest range of potential network membership. In this study the relevance is that attention should be given to the individual networks around a person and to be aware that it is likely that a significant number of contacts in one area could compensate for the absence of another type of relationship.

The researcher as a participant

In adopting an approach in which the researcher engages with the participant it is necessary to consider the potential impact of the researcher themselves

through reflecting on their role and engagement, what may be described as reflexivity (D'Cruz, et al., 2007).

Reflexivity involves reflecting on the way in which research is carried out and understanding how the process of doing research shapes its outcomes. (Nadin & Cassell, 2006, p. 208)

Whilst recognizing the limited use of reflexivity in management research there is a substantial body of literature in social work. Whilst there are a number of approaches, the common link is the role of self exploration and reviewing the researchers own values and assumptions when collecting and reviewing the data.

In this study the researcher conducted all of the interviews. The researcher is a registered social worker who undertakes senior management roles across local authority and NHS roles on a temporary basis and is a Trustee of a user-led organisation.

In conducting the interviews the researcher took the approach of a peer discussion, in line with the suggested methodology, and, in using open questions, sought to avoid adding new information to the interview. In line with the qualitative approach there was little challenge other than to understand the perspective of the participant. Of particular interest were the comments of participants that the process of a semi-structured discussion had helped them better understand their experiences and had generated ideas in terms of taking services forward.

In reporting the findings, it is noted that the initial position of the researcher was as a senior manager looking to improve service delivery. Through the

interviews this changed as the apparent behaviours of front-line staff were described, gathered from the additional information provided by cohort one. This led to a consideration of the role in policy implementation of front-line staff, and managers, and, following a post interview comment from a participating manager, Lipsky's writings on street-level bureaucracy. By the conclusion of the study the researcher had moved from looking to support the implementation of personalisation to evaluating why it was not having the anticipated impact. In developing the final conclusions there was an awareness that whilst social capital was important to the successful implementation of personalisation, it was not in the way that I originally envisaged. This required a different approach to the conclusions and the way that information was presented in the results.

As a practitioner that was involved in the implementation of the NHS&CC Act in 1993, it has been interesting to look back at the ambitions at that time and the many parallels in what personalisation is claimed to offer. It is hard not to approach some of the interview results with an air of *déjà vu* and the question as to what is different between the two implementations. In their commentary on current practice Slasberg and Beresford (2017) recognize the inadequacies of care management and then describe the implementation of personalisation as having created 'a system that is both disempowering and wasteful' (Slasberg & Beresford, 2017, p. 269). The conclusions of this study were therefore recognizing that the issues were not necessarily new or unique to personalisation, but rather dealt with aspects of the relationship between the organisation, its practitioners and the community; something we rarely get to discuss on a day to day basis.

Just as the research followed a journey as findings emerged from the interviews, so the researcher was also on a journey from the perspective of a senior manager and practitioner to that of a critical observer. Through the study this observer became increasingly concerned that the implementation of personalisation was going to result in few gains for those needing support.

The approach used

As already indicated the study took the form of interviews with participants in two local authorities. The study required the approval of the national Social Care Research Ethics Committee and the support of the host authorities who undertook an administrative role, as well as making employees available as participants.

Research Ethics approval

As the research involved two sites it was necessary to apply for approval from the SCIE Research Ethics Committee. Following an interview with the committee and amendments made to the documents for participants, approval was received in April 2012 (Appendix 4). A variation to include the interviews with managers was requested in May 2015 and agreed soon after. The decisions were confirmed by the University before the study could start.

The submission included the information for participants and for carers, consent forms, including easy read versions, and interview schedule (Appendix 2). In the variation there were similar documents for professionals (Appendix 3).

The interview with the committee covered three key areas of discussion. Whilst the members were experienced researchers they had a range of background knowledge of the subject. There was an element of confusion around the term social capital as it was seen as being directly linked to financial resources. As such it was a useful discussion, as I subsequently ensured that each interview then commenced with an explanation of what social capital means and how it might be identified.

Following on from this the next set of questions were around the focus of the research. The committee were concerned that the study was intended to create an academic justification for reductions that at the time were considered to be hidden in service changes. Given the nature of the study the key issue was the need to be independent of the developing austerity agenda and to focus on the reality of the experience of people receiving a personal budget.

Finally, there was a discussion about the implications of reductions to individual budget holders and whether in delivering the results individuals might be disadvantaged for having participated. There is an aspect that individuals might, as a result of their participation, mobilise their social capital more effectively and therefore face a reduction in their personal budgets. This was considered unlikely, but where it did it would be because an alternative resource was in place. The structure of the eligibility assessment introduced with the Care Act would have made the reduction scenario more likely (see page 79).

Selecting sites and participants

The initial plan was to seek interviews in two council areas with people that used services delivered through personal budgets. The choice of two host sites was to reduce the extent that conclusions may be influenced by local implementation arrangements, rather than national ones. The council areas were selected as they were early adopters in implementing personalisation, one was a pilot site and the other had implemented personalisation in 2008 immediately after the publication of *Transforming Social Care* (Department of Health, 2008), and were of similar scale and overall demographic nature. Both were predominantly rural with a main urban centre and secondary urban strips. Whilst both had some areas of deprivation, both are considered to be of average or above average affluence. However, the sites were not geographically close to each other and were not declaring any joint approaches to delivering services. As such their policy implementations were undertaken in isolation, although they were influenced by common national guidance, practice models and reducing financial resources. Given the limited sample size of authorities that adopted personalisation early in the process, no attempt was made to balance for different demographic populations as the result was unlikely to be generalizable. The focus was therefore on achieving two host sites that had no clear connections in designing or delivering their services. The final selection was made on their willingness to participate and the researcher's ability to attain the necessary access.

The second stage was to define the scope of the participant group. Given that the initial research question was seeking to compare the experiences of people with a learning disability and older adults there was a need to seek two

groups of participants in each area. Overall this gave four populations of individuals. An initial decision was made to seek ten participants in each population. This was based on an estimate of the time it would take to undertake interviews and to then analyse them, and what was considered to offer a reasonable spread of experiences. From the beginning it was recognised that this was an approximate arrangement and needed to be reviewed in light of the emerging results.

Cohort one

The approach taken to identify participants in the study was described as using a double blind selection process, in that the host authorities do not know who opted into the study and the researcher did not know who was invited. However, as Polit and Beck (2010) noted:

‘In the rare study in which participants are sampled at random, cooperation is rarely perfect, which means that random sampling seldom results in random samples.’ (Polit & Beck, 2010, p. 1453)

The need to allow the local authority to make the initial random selection meant that it was not possible to select participants according to particular demographic characteristics, to create a truly representative random sample. However, the approach was such that all invited participants would have had the experience of personal budgets and organising their care. In allowing the participants to opt into the study this further reduced the potential for retaining a representative randomised sample. Therefore, the approach taken could not be described as a random sample rather a purposive sample that was appropriately anonymised.

From the four populations it was anticipated that the study would be able to show differences in social capital and the way that it was used to support the delivery of care. Participants were selected by each host council from the people they were providing with personal budgets. The choices were made by non-operational managers on a random basis, with 100 names selected from each sample. Each of these 400 people were sent a postal invitation to participate, with details of the study, and asked to reply directly to the researcher (Appendix 1).

The early results quickly showed that there were limited differences between the participants involved (see Table 6.1, p109), as a result of factors not anticipated prior to the study. To achieve a greater number of participants the invitation to participate was extended to people using services by contacting about thirty service providers in each area. Again the authorities were aware of the invitations being sent, but not who responded. As a result of these invitations a final group of participants were included in cohort one. These were screened to ensure that they met the original sample description and participation was again on the basis that they opted into the study. This brought the number of usable interviews to fifteen participants.

In line with the decision to use verbal interviews it was necessary to record discussions to retain the integrity of the narrative expression and content, but to then transcribe them for analysis and record (Cohen & Crabtree, 2006). The starting position in terms of the interview approach was to prefer a storytelling style, with participants retelling their experience, but it soon became apparent that an element of direction was required to bring out the individual's unrecognised social capital. The result was that the interviews

took on the form of a semi-structured interview based on the interview schedule they received at the beginning (Appendix 2).

On four occasions interviews are described as being with a family in the results chapter. In each case it was confirmed that the individual was happy to include the carer before the interview commenced. The qualitative approach to the interview encouraged discussion amongst the family members and at times allowed them to define a response without intervention. There could have been a risk that one view would dominate the responses, but on these occasions this did not appear to happen.

Following a review of the results of the first cohort of participant interviews it was apparent that there were some common themes around the availability and access to social capital and the implementation of personalisation that needed to be addressed. Of the responses received, fifteen interviews were undertaken with twenty-two people using a personal budget, rather than the forty that had been intended. However, the high consistency of the responses in the interviews indicated that increasing the number of participants was not likely to bring forward a different perspective.

Cohort two

A vertical slice of local authority managers and social workers from the two sites were interviewed to understand the behaviours being reported by Cohort one. The introduction of the second cohort was expected to offer data with which to verify and extend the findings from the first cohort. In this way the study sought to mitigate the smaller than expected number in the first cohort

by developing a second cohort that could provide a direct commentary on the findings from the first cohort.

Each host site was asked to arrange interviews with social workers, team managers and service managers in each of older adults and learning disability teams (total of six in each authority) along with the lead for the implementation of the Care Act. In total 13 interviews were conducted with local authority participants. As the numbers of staff in these roles are now quite small there was no attempt at seeking a random sample, rather the service managers involved sought volunteers from their services. The same interview schedule was used with each person, the difference in role was reflected in the answers given rather than through differentiation of questions. These interviews also followed the same methodological approach, although the topics covered had to be developed in line with the initial results (Appendix 3).

As before the interviews mainly took the form of a semi-structured conversation, although the familiarity of some staff with the subject meant that these interviews were closer to the originally intended narrative approach. In particular, the quality of the interviews with the managers, indicated that with their wider perspective, and an element of professional confidence, they were better able to maintain a narrative discourse.

Developing the interview schedules

For the first cohort the schedule was strongly influenced by Putnam in that it sought to identify aspects of social networks and the impact they had on the individual. It went through the key indicators from Putnam's work including trust, maintenance value and reliability. Based on previous interview

experience the schedule started with an opportunity for the participant to describe their experience of care and their networks, as a way of managing initial reservations and developing some comfort in the research environment. In practice this also set the tone for the individual interview and was a source of much of the additional data that informed the subsequent development of the study.

For the second cohort the schedule started with questions around their awareness of social capital and asking the participant to reflect on the role of policy and local procedures to facilitate its assessment in practice. Recognising that individual social capital had to be captured in the assessment process (Office of Public Management, 2009) the interview considered the systems behind this. There was a substantial aspect where participants were asked to reflect on examples from their own professional experience of social capital being mobilised by individuals, particularly where it might have stimulated innovation, and whether there was evidence of a financial gain to the authority from this. Given that the first cohort had evidenced that social capital was present, the discussion with cohort two was focussed on Coleman's elements and how social capital might be mobilised.

Understanding the results

Previous research has sought to define what social capital is and the way that it operates in economic and sociologic studies. In order to identify where reciprocal relationships existed that the participant could draw from, the initial cohort was asked to describe the people that helped them arrange and deliver their care and where possible to engage participants in evaluating the impact

of this (Putnam's definition). The second cohort involved interviewing staff put forward by the two host authorities with an interview schedule intended to reflect on the experiences of the first cohort participants.

Coding and analysis

Whilst consideration was given to using database tools to tag and identify contributions, the small number of interviews did not lend itself to this type of tool; the time taken to set it up, and the reach it would have added, was not considered a good use of time. Looking at the content of the interviews the other issue would have been the ability to identify specific concepts from the range of descriptions in the interviews. As such the study followed a thematic analysis of the data rather than a textual approach as defined by Larsson and Sjoblom (2010).

The coding was first set out according to the study questions and linked to elements of social capital, and then the decision making process anticipated from the care management process. As such the first analysis followed Putnam's criteria and then led into using Coleman's six elements of social capital (see page 39). The final selection, discussed in Chapter 7, was based on repeating themes from interviews rather than a specific theoretical framework. In this way the aim of capturing data without researcher bias was retained.

By allowing the participant to control the conversation there was the flexibility for them to report on issues linked to the area of study that had not been initially anticipated. In particular, most participants wanted to talk about the processes used by council staff within the care planning activity which were

used to control the results, which had not originally been intended. However, this was such a prevalent theme that it became an area of interest, as the study continued. To better understand the detail of this a new section was added to the coding that linked comments to aspects of policy implementation theory, in particular elements of street-level bureaucracy as described by Lipsky (1980) (see page 55). This was then used to inform the development of the interviews with council staff in the subsequent cohort of the study.

During the interviews there was a strong report of social networks, giving the impression that people had available social capital. Whilst in some interviews participants were able to reflect on the strength, or otherwise, of their social capital the impact of this was not coming out in the initial analysis. As a result, each interview was re-analysed using a more detailed coding framework, breaking down the reported networks into more fields that clearly separated aspects of bonding and bridging capital. In the same way there was a need to further breakdown the comments around the process of arranging care and making decisions to better understand the data obtained. This second coding gave sufficient detail in order to support the analysis of the data presented in Chapters 6 and 7.

Polit and Beck discuss Firestone's models of generalisation and note that analytic generalisation occurs at the 'point of analysis and interpretation' (Polit & Beck, 2010, p. 1453). In particular, they suggest this is through collecting evidence closest to the concept being studied and identifying that which is most common to the greatest number of participants.

'In the course of their analysis, qualitative researchers distinguish between information that is relevant to all (or many) study

participants, in contrast to aspects of the experience that are unique to particular participants' (Ayres, et al., 2003, p. 871).

Ayers et al go on to say that the interest is in aspects of a 'case' that can be identified across a number of people rather than the potentially unique experience of one person. For this reason, the data is presented in a series of tables that show the number of times each participant refers to a specific concept. In line with Eisenhardt and Graebner's (2007) proposition that each case study be considered an individual 'experiment' each interview was analysed in isolation before seeking to collate results (see p96). This readily demonstrated areas of aggregation and absence upon which to build an understanding of group wide themes.

The coding provided a significant amount of detail that was difficult to describe concisely. As a result, data relating to Putnam's bridging and bonding ties were extracted and are presented in Chapter 6. This was followed by data relating to Coleman's six elements. Although appearing as numerical tables, this was intended to support aggregation, not create a quantitative data set. In Chapter 7 the research engaged with the data from cohort one that could be aggregated that was not linked to the social capital theorists. At this point attention was given to existing theoretical models to understand what was being reported and in particular look at it through the lens of street-level bureaucracy to understand the barriers to the mobilisation of social capital.

The third chapter of results (Chapter 8) looks at the local authority staff's responses considering their experience of social capital, and policy implementation, in particular the behaviours identified as those of street-level bureaucrats In the second cohort the results could not be easily coded for

analysis as a single group. As there were essentially four groups of participants (social workers, team managers, service managers, and policy officers), with different types of engagement with the subject, each had to be reviewed separately. This was different to the first sample where the anticipated differences between populations were not supported by the findings in that all the populations reported similar engagement with social capital and similar experiences when dealing with local authority staff.

As with many qualitative studies, this is seeking to provide a contribution to the emerging understanding of, in this case, the role of social capital in delivering care and support. Whilst there are some clear conclusions from the interviews and the associated literature, it is inevitable that further evidence will be required before they can be considered as robust and usable.

CHAPTER 6. ESTABLISHING THE PRESENCE OF SOCIAL CAPITAL

Introduction

In looking at the impact of social capital on the personalisation of care the interviews sought to identify the range of individual networks and what these then contributed to individual support arrangements, either in terms of innovation or as alternative approaches to meeting needs. The aspects of social capital may be seen as care and support being offered, participation with or delivery of tasks to support the individual, or the provision of social or emotional support. In addition to the presence of a social network Putnam also set out expectations around reciprocity, value and reliability and that relationships had to be current implying a need for maintenance. The intention was to not only identify if the elements of social capital were present and being mobilised, but also, if it was possible, to ascribe a value or scale of the care received by the individual. It would then lead to a discussion as to whether the difference in social capital between groups of individuals could have an impact on the cost of their care.

A profile of participants in Cohort One is shown in Table 6.0, below. This shows that 22 participants were interviewed regarding 15 care arrangements. As described in the definitions in Chapter 1, in the following report the term participant is used as the overall term for those interviewed; where it is necessary to be more specific, such as the comments of a specific person, they are referred to by their role such as 'carer' or 'service user'.

Participants		Host	Role	Relation to SU	Gender	Age group	Employment status	Residential status
Family 1	OA	A	Service user		M	65+	Retired	Home owner
			Carer	Wife	F	65+	Retired	
Family 2	LD	A	Service user		F	60-65	Supported	Home owner
			Carer	Step-mother	F	65+	Retired	
Individual 1	OA	A	Service user		F	65+	Retired	Home owner
Individual 2	LD	B	Service user		M	40-49	Supported	Residential care
			Carer	Support worker	F			
Family 3	LD	B	Service user		F	18-25	Supported	Home owner
			Carer	Parent	F	40-49	Not working	
			Carer	Parent	M	40-49	Employed	
Carer 1	LD	A	Carer	Parent	F	40-49	Employed	Home owner
			Carer	Parent	M	40-49	Employed	
Carer 2	OA	A	Carer	Daughter	F	50-59	Not working	Home owner
Individual 3	OA	A	Service user		M	65+	Retired	Home owner
Individual 4	OA	A	Service user		M	65+	Retired	Social housing
Individual 5	OA	A	Service user		F	65+	Retired	Home owner
Carer 3	LD	B	Carer	Parent	F	40-49	Not working	Home owner
Individual 6	OA	B	Service user		M	65+	Retired	Social housing
Family 4	OA	B	Service user		F	65+	Retired	Home owner
			Carer	Husband	M	65+	Retired	
Individual 7	OA	B	Service user		F	65+	Retired	Social housing
Individual 8	OA	B	Service user		F	65+	Retired	Home owner

OA= Older Adult, LD= Learning disability

Table 6.0 Cohort 1, sample profiles

Social Networks

This section was analysed using Putnam's description of social capital as being the network of contacts the individual participates in. The resulting table separates the data into a range of different types of networks. The network types in the table were defined by the data from the participants to support an understanding of the range of individual social networks. The resulting commentary then considers the level of reciprocal support from the different classes of ties and those that should not be considered as social capital.

Each interview was analysed as a single set of networks, although it may be a single participant (the individual or a carer) or the individual with one or two informal carers. The exception was Individual 2 who was interviewed along with a paid carer he had asked to be present.

Interview reference	Participant profile	NETWORKS									Total
		Friends	Family	Employment	Clubs/Church/ Day centre	Paid carers & professionals	Internet	Other users/carers	Family professionals	Other	
Family 1	O A C S A	3	6	4	2	3	0	0	1	0	19
Family 2	LD C S A	2	0	3	8	4	1	3	1	0	22
Individual 1	O A S B	2	4	4	1	8	0	1	2	0	22
Individual 2	LD C S B	1	3	0	3	3	0	0	0	0	10
Family 3	LD C S B	0	3	0	4	2	0	4	0	0	13
Carer 1	LD C A	4	3	1	9	2	1	1	1	0	22
Carer 2	O A C A	3	3	0	0	7	1	1	0	0	15
Individual 3	O A S A	2	5	5	3	7	1	0	0	1	24
Individual 4	O A S A	2	3	2	4	5	0	0	0	1	17
Individual 5	O A S A	5	2	4	0	5	0	0	1	0	17
Carer 3	LD C B	4	4	0	6	7	1	7	0	0	29
Individual 6	O A S B	4	0	1	2	7	0	0	0	0	14
Family 4	O A C S B	1	4	2	3	4	1	0	0	0	15
Individual 7	O A S B	9	9	0	1	8	0	1	0	0	28
Individual 8	O A S B	3	3	2	2	4	0	1	1	0	16
Totals		45	52	28	48	76	6	19	7	2	
Participant profile: OA-Older Adult; LD-Learning Disability; S-Subject; C-Carer; A-Council Site A; B-Council Site B											

Table 6.1 Coding table for social networks

Overview

As noted by Butt (2008) the total number of contacts is only an indication as to the likely level of social capital an individual might be able to access, it is not a definitive measure. The two lowest results were from interviews with people that did indeed feel isolated, either as they were in a care home (Individual 2) that made moderate moves to integrate residents with local services or a family (Family 3) that describe themselves as having little support outside their immediate network.

It is noticeable that there were a limited range of networks for each of these participants, and the tone of the interviews indicated that they were all aware of this. For Individual 2 his focus was on moving to share accommodation with his brother, something that the paid carer with him was clearly unaware of and potentially indicative of it being an unrealistic goal, possibly an example of him trying to find a meaningful link outside a unit he did not want to be in.

Conversely the two highest scores were participants (Carer 3 and Individual 7) who felt well connected to their communities and enjoyed an element of independence in the decisions they made about their lives. As was noted by Butt (2008) there was a variation in their experience, with some aspects (notably through employment) where neither had a network, yet this did not diminish their positive overall view of their social network. The other person that gave a strong indication of being independent (Individual 1) had low numbers of friends and did not get involved in social activities, other than the local church, although she had a good representation of bonding ties through family members.

In line with the work of Putnam (2000) the indication is that most people do have multiple social networks that appear to be reciprocal, establishing the first aspect of Putnam's description of social capital, and therefore there is a need to test whether these networks have an impact and can be relied upon in order to demonstrate that social capital is being mobilised.

Paid Carers

In terms of the definitions of social capital the network of paid carers would not be considered to be part of a person's social capital as reciprocity could not be demonstrated. Yet the strong personal relationships between participants and certain paid carers meant that their contribution outside of their 'paid for' role has to be taken into consideration.

Reading the transcripts, it is clear that paid carers are very influential in guiding individuals in their choice of support provider and the way that support is delivered. When looking at the potential to draw on social capital to support innovation the two people actively using a personal assistant (Individual 1 and Family 2) had used the knowledge of people employed in social care that had a good understanding of the local arrangements. Individual 1 noted:

I fought against it for a long time, being a disabled person for 30 years I did fight against it but then I realised that my quality of life was reducing because I wouldn't accept it so once I accepted it and thought 'well I've got to go for this' having worked in the field and helped other people do it I was quite happy to proceed. I don't know if I'd have been quite as happy without that background information. (Individual 1)

Whilst Coleman set out information sharing as evidence of social capital, in neither case was this as a result of an existing reciprocal social network and

may better fall into Becker's criteria of human capital (specifically knowledge learnt through experience).

The interviews suggested that the influence of the paid carer on the delivery of support was stronger than that of family and friends, who are typically considered by front-line local authority staff as the main support when planning care. The deciding factor is whether there is any reciprocity in the tie to paid carers, without which it would not be considered as being a contribution to their social capital.

Participants were clear that their relationships with these paid carers were the result of market exchanges, and that there was no obligation or expectation of the paid carer to act outside of their role. Where this happened it was recognised as being exceptional. As such the participants were reporting that, in line with the literature, paid carers were not typically considered to be part of their social capital.

Family

As anticipated family members made up a significant aspect of the contacts an individual had. Equally apparent was the range of engagement this offered, with some being in very occasional contact and others providing support for substantial parts of the week (see table 6.2). The commitment was typically most concentrated where the participant lived with the family member, rather than being linked to the number of family members involved. It is worth noting that two reported no family contacts at all, whilst several others mentioned family that lived too far away to be involved on a regular basis. The carers in Family 3 reported *'No we haven't got any family at all. My husband's family*

are not on the scene and my two sisters are in London, her (the subject) brother is in Australia.' So, although there is an element of a wider family network, in practice this offers them no tangible support. Meanwhile Individual 7 saw little of her family, who also lived mainly in London, but its presence and the occasional visits to her relatives was a strong aspect of her personal identity and emotional support, typical of bonding ties.

Generally, the contact with family appeared to remain important, regardless of the amount of contact that actually occurred. Subsequent contact with Individual 6 indicated that he does have family that he is in contact with (a son and grandchildren) but the absence of them being mentioned in the interview indicates that they probably have a marginal role in the planning and delivery of care and support, which was the context of the interview.

The number of family links maintained by older adults and by those with a

	No support	Low support	High support	Total
Older Adults	1	6	3	10
Learning Disability	1	1	3	5

Table 6.2 Level of support by grouping

learning disability did not appear to vary significantly. In contrast the support offered by family members did vary as noted in Table 6.2. During the interviews participants were asked about the practical support from their families. Where this was low the basis varied with Individual 1 who said it had been a deliberate choice so as to maintain her own independence.

I didn't want to rely on my daughter, my son or my grandchildren. They've got their lives to lead and anyway, it's my life you know, how can I say to them don't do things like that, you can't not with your family. (Individual 1)

For another it was a result of her choice to geographically relocate at an earlier point in her life (Individual 7). In both cases the on-going social contact with family members was strongly valued, justifying them as bonding ties.

The results indicate that whilst contacts with family members are variable in terms of the amount of support being offered, the emotional and social value they bring are considered very important to participants' personal identities. In terms of its contribution to social capital this network has a clear place, the variable factor seems to be the ability of people to draw down on it. Putnam described family links as bonding ties (the strongest form), the participants in this study were showing that this was not consistent true.

Friends

Whilst there was a notable outlier (Individual 7), in general participants reported 2-4 substantial friendships. Although one interview (Family 3) identified no friends, its content indicated that the main social contacts were either other people with a learning disability and their families, or members of the local church. Putnam would include these social contacts as aspects of bridging ties, although there may need to be further assessment as to the level of reciprocity involved.

No interview indicated that friends were involved in providing personal care, rather that they provided support with transport, shopping and social contacts (see table 6.4, p.126). As such there was a similarity with people met through social clubs in that they both provided support that would not be offered by the local authority, although long-term friends tended to offer a higher commitment. Where friends were involved in providing support it appeared to

be where friendships had been in place for a longer period. This links with Putnam's writing that social capital needed maintaining and Bourdieu who said it was a property that was accrued over time.

In general, it was not possible to identify a strong contribution from the network of friends towards the planning or delivery of support. Again, as with family, they provide a rich social context and emotional support, along with low level support that would not be available from current social care resources such as shopping and dog walking. As such there was some evidence of the bonding ties creating greater support compared to bridging ties.

Clubs/Church/Daycentres

The attendance at day centres was a common experience for people with a learning disability and was valued for the social contact. However, this group also had a range of other activities, such as going to church or evening and weekend social clubs, which together made up the main part of their social activities. With one exception (Family 2), within the interviews there was no evidence that these networks resulted in a specific benefit around the planning or delivery of care.

Whilst the group of older adults had less involvement in clubs, church engagement was a regular outlet. Participants reported that it was the long-term involvement with interest groups that resulted in support being provided to the individual from other club members. This was to support the participants continued engagement with the common interest, and the social value of this, rather than a contribution to the care being considered by the

local authority. Examples found were fellow members of a social club that regularly exercised the dog of a fellow member who was no longer well enough to do so (Individual 4) and, for another participant, provided transport to club and special interest events where the participant was acknowledged to have an exceptional contribution (Individual 3). In both situations the support was essential to the on-going social wellbeing of the participant, but was of a type that was excluded from consideration by both local authorities. In terms of social capital these contacts may be considered as bridging ties.

For two participants this network ceased to be engaged as the participant stopped attending either as the facility became inaccessible due to increased impairment (Family 4) or the family moved to a new area (Family 1). This demonstrated the fragile nature of the social networks and the importance of actively maintaining them over time, as Putnam noted. When this was discussed with one of the well-connected participants (Individual 7) she was aware that she did maintain her networks, but was not able to articulate how she did this. That the obvious examples of networks coming to an end were those of clubs and social groupings indicates that these are probably more fragile, or harder to substitute, than those of friends.

The inclusion of day centres in this type of network was based on the range of social links that resulted, which were not necessarily formed through friendships. Whilst participants spoke of people they knew at the centres, there was limited contact outside in their own time making these bridging ties at best. Whilst people with learning disabilities saw day activities (reflecting the range of social, entertainment and employment focussed support) as being a major part of their week this was not the same for older adults in the

sample. Although a number of the older adults were involved in a day centre, this was seen as peripheral to their network of support. It was not evident in the interviews that this involvement in day services had an impact on the development of overall care outside the day activity, despite there being regular contact with care professionals. In this sense it is a very different quality of relationship with individuals compared to paid carers that visit the home. The only exception to this was with Family 2 where the contact with a day centre carer resulted in a personal assistant arrangement.

Overall the study showed that, whilst day activities were a common network for many people, their role was typically limited to that of a social engagement and rarely went beyond that to offer the reciprocal support necessary to be considered as a bridging tie within social capital. Some social capital was derived through social /community activities, as bridging ties, but the value of these were weak and required ongoing maintenance that was not always possible.

Employment

The results around employment were variable, with nearly half of the participants reporting little or no employment networks. In part this may be due to the time since the participant was last working, but also that for those with a learning disability it was because they had no experience of work as a social environment. What was common in the interviews was that, for 13 of the participants, former work relationships had no impact on their support nor were they an on-going social outlet. Of the remaining two, one received very occasional social contact (Family 4) whilst the other had some limited

practical support (Individual 4). At a social level, former employment was a strong aspect of personal identity and formed part of the discussion:

I was in the voluntary sector and I managed the project that supported disabled people to obtain independence and maintain it. (Individual 1)

There did not appear to be any expectation that former colleagues would maintain contact after it had ended so when they did it was worthy of comment:

Oh they don't arf change in three years, or two years. No they treated me all right. Well I worked hard and that was it like. I still see them like. (carer, Family 4)

The exception was Individual 5 who continued to maintain a strong link with associates of her previous employer, who had offered to help meet her medical and support requirements. This was considered a potential outlier as it was made by members of an African community who may have had different expectations and obligations in social capital. By remaining in the UK she was not able to avail herself of the offer.

Given the previous comments about the need to maintain networks to benefit from them it is not surprising that, with a group of older adults that have not been in employment for a number of years, the benefit from these relationships has now reduced to the point of almost disappearing. For those with a learning disability there was no evidence that employment was a factor in their social networks. It occasionally occurred in their carers' networks, but not as social capital in that employment did not appear to be a network against which support could be drawn. As such employment networks would

not be considered to offer a contribution towards the participant's social capital.

Other people using services or carers

Only half the participants spoke of receiving any support from other service users or carers. Notably the three highest numbers of contacts came from the carers of people with a learning disability, whilst the older adults or their carers rarely made contact with others in a similar situation to themselves. The links with other users and carers was clearly demonstrated by Carer 3 who described these contacts as being of three types.

Firstly, there are the contacts her son had with peers which were social and formed a spectrum of community engagement for those with similar needs to his own, those with people with a range of impairments and those with none. This was also shared by Family 3. Some of this led to bridging ties, but the interviews indicated that many did not.

The second group of contacts are informal contacts made between informal carers where there does appear to be an element of mutual support and information sharing (bridging ties). This was similar for carers of both older adults and people with a learning disability. These links were typically building on existing social contacts where the participants recognised someone with a similar experience.

The final set of contacts were through carers groups. The main currency of these groups appears to be the information and knowledge to be gained from

others, which meant that groups that were seen as a place to moan were avoided (Carer 3).

My sort of experience, I tend not to go to these sort of groups and things because my experience is they're all very much doom and gloom and moaning, instead of being constructive they're all out to get the professionals and moan, I'm not into that. (Carer 3)

Overall carers groups were not seen as a core source of information and support for participants and were not described by participants in terms linked to social capital. This is a significant challenge to the traditional practice of local authorities, which have tended to use support groups as a key communication tool and central to consultation exercises. The implication is that, whilst a useful resource to draw on when developing support arrangements, this aspect of social capital was weak in terms of the support of on-going care.

Professionals within the wider family

In six interviews participants noted that a family member was involved in health or social care services on an employed basis. These family members represented a spread of roles that included carers, front line professionals as well as managers. However, in each case the participant had not sought advice from these family members as to the most effective way of planning and delivering care. According to one family they had not thought about it (Family 2), a position that appeared to be common to other participants.

In terms of social capital this seems to have been an obvious opportunity to draw on an established resource of Coleman's information potential when

services were being planned. From the interviews there was no evidence that this aspect of social capital was being mobilised. It was the result of participants' decisions not to engage with this network that initiated the question about the role of the professional and whether this needed further consideration. Not only was there no evidence that participants sought access to this information potential, there was no evidence that it had been offered.

Internet and Social Media

At the start of the study this had not been considered as an area of interest, although there was a move towards making information more accessible. Six participants acknowledged that it was a source of information that they used, although there was a common position that the lack of any consumer review or rating of the information presented meant that they were not able to evaluate its usefulness. The proposal for a rated service, as appears on many e-commerce sites, was thought to be helpful. There is a developing literature on the link between social media and social capital (Steinfeld, et al., 2008), but no evidence was found in the literature as to how it could support people looking for care or information on which to base decisions.

Some participants had started to use social media platforms to share information or communicate with others, which would have then been a direct aspect of the information potential within social capital. Although new to using the internet on a regular basis, the generation now coming forward seem to be more aware of on-line resources and the contribution this can make to planning and delivering support (Prescott, 2015). It is likely that future studies

will need to be aware of this element as it offers a new way of accessing social capital.

Reflecting on the analysis above of the network of support groups, the proposition to be tested would be whether social media could become a more reliable alternative, as it offers the opportunity for information to be openly moderated and therefore to gain some reliability. As such it could better fit the test of reciprocal social capital in that individuals could invest (contribute), withdraw (take advice) and be involved in developing a particular network of contacts.

Elements of Social Capital

Having established that people have developed a range of supportive networks, the second question was whether these then have an impact on the way they plan their care and maintain themselves. Specifically, the literature indicates that the contributions that networks offer should have value and be reliable (Putnam, 2000). The earlier section on networks also indicated that the best support came from those networks that had remained current, as Butt (2008) had identified. In this analysis attention was therefore given to identifying how participants sought to maintain their social capital as a way of capturing whether it was likely to be a source of support in the future.

The headings in table 6.3 refer to the conditions required to develop social networks into social capital, based on Putnam's description (2000). Whilst the strengths of these conditions were not tested individually the responses tended to indicate that the social networks identified earlier were not being actively mobilised.

Interview reference	Participant profile	Trust & commitment	Maintaining Social Capital	Value of Social Capital to individual	Reliability of Social Capital
Family 1	O A C S A	0	4	0	0
Family 2	L D C S A	1	4	1	0
Individual 1	O A S B	0	0	1	0
Individual 2	L D C S B	0	0	0	0
Family 3	L D C S B	0	1	0	4
Carer 1	L D C A	0	0	1	0
Carer 2	O A C A	0	0	1	0
Individual 3	O A S A	0	1	3	0
Individual 4	O A S A	0	0	2	0
Individual 5	O A S A	0	3	0	0
Carer 3	L D C B	0	2	0	0
Individual 6	O A S B	0	2	0	0
Family 4	O A C S B	0	0	0	0
Individual 7	O A S B	0	1	2	0
Individual 8	O A S B	0	0	0	0
		1	18	11	4
Participant profile: OA-Older Adult; LD-Learning Disability; S-Subject; C-Carer; A-Council Site A; B-Council Site B					

Table 6.3 Coding table for elements of social capital

Commitment and reliability of social capital

The results show a strong response in the participants' view that their social networks were not something that they were actively engaging with when planning and delivering their support. It cannot be said that they did not trust others or value their commitment; rather that it was not something they expected or planned for. As such there was no evidence that they were actively engaging their social capital to the full.

Given the limited confidence that participants had in the commitment and reliability of their own social capital it is interesting to note that many were able to identify ways that they had supported others. The most obvious was Individual 7 who talked about the network she had that included senior public

sector managers. This did not offer her a direct gain, but was one which she thought was valuable to other service users in her network.

I've found that, you know, my connections haven't made any difference to me whatsoever. I hope that my connections have made a difference to what is happening with the service users at [the user-led day centre]. (Individual 7)

As such it may be that the engagement of social capital is sufficiently subtle that it is not identified by the participants. For example, subsequent contacts with Individual 6 indicate that he has support with correspondence from a volunteer at a day service he uses, when his health is poor, which he did not mention in the interview. This was part of his social capital that he did not see as part of his support and is very much unrequested, but relied upon.

Lin (2001) described social capital as being an investment in social relationships with expected returns, and yet what the interviews have been indicating is that people have been investing in their networks, but have not been explicit, even with themselves, as to what they expect back from them. If social capital is to become a part of the social care model then Kramer (in Bartkus & Davis, 2009) would argue that there is a need for the community to share a common set of values that can be focussed on, using it as a collective response to the problem (the need for care).

Maintaining Social Capital

The value of social capital has to be maintained if it is to continue to be of value to the individual (Olstrom in Bartkus & David, 2009). Otherwise, she notes, it will quickly dissipate and is then very difficult to restore. From the interviews, half demonstrated behaviours that would be considered to have

been maintaining social capital, such as the carer in Family 2 being actively involved in the village church and supporting an older adult in the local community.

The group that were not maintaining their social capital were also those that, in the interviews, came over as being the more isolated within their networks. The coding shows that the person with the highest number of networks that was not maintaining their social capital (Family 4) was below the mode for the number of networks in the sample. As such this is a further indicator that the social networks supporting people to plan and receive care do behave as typical aspects of social capital, requiring active maintenance if they are to be able to offer a current benefit.

The value of social capital

In this section the focus was on the practical tasks undertaken by the person's social network – the result of their social capital. Whilst not evaluated in financial terms, the implication is that it has an indirect financial gain for the person and potentially the state. The response from the coding was interesting in that the recorded comments were not always in line with the evidence provided. Specifically, in terms of the value of contributions, part of this difference between the value noted in interviews and actual support delivered is likely to be that immediate family carers were not seen by participants as part of their available social capital, yet they were often a substantial part of the support being received.

From table 6.3 the value of their informal support was recognised by seven participants. The following table (6.4) was developed either by extracting

Interview reference	Participant profile	Supporter	Level of informal support provided	Type of support	Potential cost to local authority (estimated)
Family 1	OA C S A	Wife	Constant 24/7	Personal care Food preparation Transport Social and Leisure Supervision	14 hr/week
Family 2	LD C S A	Step-mother	3 day/week and most evenings	Some food preparation Supervising personal care Transport Social and leisure Supervision and Managing support	30 hr/week
Individual 1	OA S B	Daughter	1-2 hr/week	Social and leisure	
		Son	1-2 hr/week	Social and leisure	
Individual 2	LD C S B	None			
Family 3	LD C S B	Parents	4 day/week and most evenings	Personal care Food preparation Transport Social and Leisure House cleaning Supervision	15 hr/week
Carer 1	LD C A	Parents	5 day/week and most evenings	Personal care Food preparation Transport Social and Leisure Supervision and Managing support	15 hr/week
Carer 2	OA C A	Son-in-law	Live-in 5days a week*	Personal care Food preparation Supervision	20 hr/week
		Daughter	20 hr/week	Managing finances Managing care and support Providing support Engagement with community	
Individual 3	OA S A	Friends	2-3 hr/week	Social and leisure	
Individual 4	OA S A	Friends	7-8 hr/week	Social and leisure Dog walking	
Individual 5	OA S A	Niece	1-2 hr/week	Shopping	
Carer 3	LD C B	Parents	30 hr/week	Personal care Food preparation Transport Social and Leisure Supervision and Managing support	30 hr/week
Individual 6	OA S B	Friends	14-20 hr/week	Shopping Managing correspondence Community engagement	4 hr/week
Family 4	OA C S B	Husband	30-40 hr/week	Some personal care Supervising mobility Food preparation Transport Social and leisure Managing support	14 hr/week
Individual 7	OA S B	Friends	2-3 hr/week	Social and leisure Accounts	
Individual 8	OA S B	Son	1-2 hr/week	Support with affairs	
		Daughter	5-6 hr/week	House cleaning Shopping Managing finances Correspondence	
*Carer 2: The family chose to provide higher levels of care during the week and then to buy a live-in carer at the weekend because they were concerned at the risks involved. This concern was not shared by the social worker.					
Participant profile: OA-Older Adult; LD-Learning Disability; S-Subject; C-Carer; A-Council Site A; B-Council Site B					

Table 6.4 Anticipated value of informal support extracted from interviews

aspects of support mentioned in the interviews or by looking at the support required in addition to that provided by the local authority. This showed that only one person had no informal support, whilst the others received a range from one hour a week up to constant support and supervision.

When looking at the availability of networks the interviews were giving an indication that the tasks being undertaken informally were typically those that the local authority criteria would not allow for, including house cleaning, shopping and walking pets. The eligibility criteria in place tended to focus on functional tasks with limited allowance made for promoting safety in a participant's own home or engaging in external activities such as shopping or accessing leisure pursuits. In order to understand the value of the informal support provided, the current support was noted and an assessment was then made as to the likely level of support that would be offered if no informal care was offered. These are necessarily estimates as the eligibility criteria changed to a national scheme in 2015 and may still vary according to local interpretation. The value of the informal support would therefore be the potential cost to the local authority of substituting for the care provided.

The table 6.4 shows that most participants received some support from their networks that could be ascribed a value. The exception was the participant in a care home where it would require more detail to understand if he was admitted to a care home as a result of the lack of good social capital or whether being in the home resulted in its loss. That investigation would be outside the ethics approval for the methodology. From the evidence in the interview it would appear that, when his parents died, Individual 2 had lived for

a short time with a sibling and then went into an emergency placement, implying a lack of realisable community support.

Seeking Support

	Participant profile	Information giving	Information lack	Own search	Innovation
Family 1	O A C S A	1	3	3	0
Family 2	LD C S A	0	2	0	1
Individual 1	O A S B	0	1	0	0
Individual 2	LD C S B	0	1	0	0
Family 3	LD C S B	0	3	0	0
Carer 1	LD C A	0	5	0	0
Carer 2	O A C A	0	2	1	2
Individual 3	O A S A	0	2	0	1
Individual 4	O A S A	0	2	0	1
Individual 5	O A S A	1	0	0	1
Carer 3	LD C B	0	5	0	0
Individual 6	O A S B	0	2	0	0
Family 4	O A C S B	2	1	0	0
Individual 7	O A S B	0	0	0	0
Individual 8	O A S B	0	3	0	0
		4	32	4	6
Participant profile: OA-Older Adult; LD-Learning Disability; S-Subject; C-Carer; A-Council Site A; B-Council Site B					

Table 6.5 Responses to questions on planning care

Participants were asked about the approach they used to identify the support they were receiving as a way of understanding the impact of Coleman's information potential of social capital and whether it had contributed to the innovation sought by personalisation. Responses were coded on the basis that they received helpful information, occasions where they struggled to obtain information and where they had undertaken a search based on their own initiative (table 6.5). A note was also taken where participants considered innovative approaches to service delivery, even if that did not result in them taking that route.

The introduction of personalised care came with two significant aims – giving individuals the opportunity to develop their own care arrangements and making it possible for individuals to explore innovative approaches to

receiving support. As noted above, two individuals took the opportunity to employ their own care staff (Family 2 and Individual 1), the rest agreed to use a range of different care providers with agency carers coming into their own homes or using institutional care at day and residential units.

The reasons for this varied, with many saying that they had made a choice not to be an employer so took the alternative on offer. The most common reasons given for not taking on a Personal Assistant were the complexities of being an employer and issues around recruitment of staff that would be sufficiently reliable (Individual 8, Individual 6 and Carer 2 gave examples of this in their discussions). In this way one of the most promoted innovations available through personalisation was being blocked.

The tendency towards employing staff did not appear to be related to social capital in that those employing carers were not necessarily those with the highest number of networks, but were those that had direct contact with others that employed staff. There was no evidence that this was an outcome from social capital in that the networks involved were not within Putnam's concept of bridging or bonding ties. The other type of innovation found, Carer 2, arose through the family seeking a compromise with their parents and was not based on any specific desire to innovate. They sought support, in the form of information about employing staff, but found it inadequate, resulting in a return to agency use. Such was the detail available around the difficulties in realising innovation that it led to a development of the interview schedule for cohort two and was covered as an issue in its own right.

There was also a strong theme about the lack of information, or difficulty in accessing it, in many interviews. Whilst many had received leaflets the detail was insufficient; one participant had used the internet and found that what he was being told by staff conflicted with the position in policy documents:

Partly on the internet, partly through the [local centre for independent living] who put me in contact with organisations that get the source documents, which they sent to me. So I [...] went back to their actual documents which they incidentally don't provide to people. When I had, [...], the financial assessment, they didn't give me a document which said that these are all the conditions and what you're allowed and what you aren't allowed. I had to find out for myself, and all I was getting was [them] asking me questions and giv[ing] me an output saying that that number comes out to ... you got to contribute £300 per month, but it's totally opaque as to how to get to [that] from a verbal statement, ticks in a box, to a number. (Individual 3)

The number of occasions that people talked about a lack of information was a concern, given that a need to improve information has been in most guidance since the *Our health, our care, our say* white paper (Department of Health, 2006). As previously noted there may be an issue in that communications from local authorities are increasingly using online tools along with information through stakeholder groups. Online access was noted as a tool within this sample, in line with overall internet access in the community increasing significantly with 72% of adults using the internet daily in 2015 compared to 45% in 2006. Of particular interest is that by 2015 only 32% of older adults (64+) had not used the internet and that 33% of adults using public service sites were looking for information (Prescott, 2015). In Coleman's work the access to information was one of the resources offered by social capital. Where social capital is not being mobilised, as is being found here, moving information on-line would be an opportunity to mitigate this impact.

There were examples of front-line staff providing good information and advice (Individual 5) and other situations where the participants presentation indicated an assessment of capacity might have precluded offering more flexibility in managing care finances (Individual 4). However, these were a minority and need to be seen in the context of the overall behaviours of local authority staff in the next section.

Decision Making

When initially drawing up the interview schedule the plan did not include looking at decision making in any detail. However, it quickly became apparent that the policy objective of transferring decision making to people needing support was not happening, and instead professionals were retaining much of the control of care planning. Indeed, this is clearly demonstrated in table 6.6 where the combined influences of front-line professionals and their organisations were the biggest factor. This is important to the study as it has an implication on the individual's ability or willingness to mobilise their social capital.

	Participant profile	User	Carer	Professional	Managerial/organisation	Finance service
Family 1	O A C S A	2	2	4	1	1
Family 2	L D C S A	0	2	0	2	1
Individual 1	O A S B	1	0	0	0	0
Individual 2	L D C S B	2	1	1	0	0
Family 3	L D C S B	0	1	1	0	0
Carer 1	L D C A	2	3	1	0	0
Carer 2	O A C A	2	5	0	1	0
Individual 3	O A S A	1	0	0	3	0
Individual 4	O A S A	3	0	1	1	0
Individual 5	O A S A	1	0	2	0	1
Carer 3	L D C B	1	5	1	0	0
Individual 6	O A S B	0	0	2	0	0
Family 4	O A C S B	0	0	0	0	0
Individual 7	O A S B	1	0	0	1	0
Individual 8	O A S B	2	0	3	2	0
		18	19	16	11	3
Participant profile: O A-Older Adult; L D-Learning Disability; S-Subject; C-Carer; A-Council Site A; B-Council Site B						

Table 6.6 Evidence of decision making

Coleman proposed that the individuals' interactions with authority were influenced by their social capital, that through support from their social networks individuals were better able to understand how to access a positive response from organisations and authority figures. This was not supported by Putnam (Lin, 1999). In looking at a person's relationship with an authority the consideration is with what confidence the individual is able to assert their needs and be heard and how their social networks directly or indirectly support them in doing this.

Table 6.6 sets out where participants reported that decisions about their care were being made. As noted previously, dependence on quantitative data at this level cannot be relied upon. Two participants (Individual 1 and Individual 7) only had a single reference to decision making as they were both very much in control of the planning and delivery of their support. The nature of the interview indicated that further exploration around the point of decision making with these participants would not have added to this detail. Carer 3 was also very much setting out the plans for her son, although she saw the long-term benefit of negotiating with the local authority to obtain the resources need to support him. She came over as willing to accept some compromises around decision making, as long as the overall intention to deliver an approach that supported her son was there.

These examples were the exceptions; the other interviews gave the impression that professionals controlled the care arrangements either directly or through managing the availability of resources as choice architects. Where there is a carer living with the participant, the indication is that they tended to have a strong (although not decisive) influence over decisions, although with

Family 1 there was evidence that whilst the carer had a strong influence this was based on a previous working relationship they had and was evidence of a mature approach to decision making in general. Even in this interview, with participants that had been in the care industry, they were indicating that their ability to influence the outcome was significantly restricted by the local authority actors.

It is easy to criticise the professionals for holding on to control. In the interview with Individual 6 it was clear that he had not been able to manage the care being set up and had struggled to understand the different elements that had been set up for him.

In the end I did go [to the day centre] but the amount of time I was spent in [the hospital ward] when I shouldn't have been in there and there was no need to, but they insisted that the only way I would get out was if I agreed to a care package and what they worked out was 4 times a day. Which, OK fine, they can do certain things but the majority of things you would normally do you aren't allowed to do and I'm a great believer in the old adage if you don't use it you lose it.

No. No I don't know who organised the care package. (both Individual 6)

In part this was due to the complexities of hospital discharge arrangements and the reablement arrangements being used, but it was also influenced by his recent illness that had resulted in hospitalisation. In such a situation it is not unsurprising that front line workers felt the need to manage the process, as they would have been mindful of his mental capacity at that time, but the way that it was done had clearly confused a participant that in the past had been well aware of health care services. Being in hospital he was isolated from much of his social network and the support this could give him.

In the analysis of social networks there was evidence that paid carers had an influence on the engagement of participants and their choice of agency. When looking at decision making this influence was not evident; that professional decision making as to the type of service and choice of provider was reserved to the social work team, not the provider staff.

There is also a need to be cautious about Individual 2 as, in his case, decisions were made for him in a crisis by a social worker, probably in consultation with his siblings, but the real opportunity to participate in the decision was tokenistic and did not take into account his ability to reflect on the life he wanted to live. Since then, in the care home, his views were again sought, but the real ability to implement decisions remained with front-line staff.

C So S1 worked in the care home and who helped you decide ... how did you find [this care home]? Did you look on the Internet or did you go and visit more care homes to see which one you wanted.

S This one.

C You just visited this one. You didn't see any other places?

S No.

C Who helped you to call this and sort it out. Was it your sisters? Your family? Social worker?

S Social worker.

C A social worker helped you find this place.

S Yes.

(Individual 2 and his carer)

The Presence of Social Capital - discussion

The experience of those using services showed that participants tended to have a range of social networks that they drew on. The value of these networks could not be calculated in financial terms, although it is possible to look at an equivalence with the local authority services that might be needed if they were absent. Based on these interviews the main value of the social capital being accessed was in the type of informal support given to people that would not be met by local authorities, but which makes day to day life possible. Tasks such as shopping or accessing recreational activities are often part of the benefit anyone might receive from social networks, but for the participants this was more intensive and depended upon. However, these activities were outside the daily activities of living on which eligibility criteria are mainly focussed. As such it would be difficult to identify an equivalence based cost for this social capital.

Whilst a range of networks were identified, examination of their strength as ties showed that many, such as employment and day centre attendance, did not offer the trust, reciprocal commitment and value that qualify them as social capital. For the elements that did contribute the value was typically low and, more importantly, were not seen as something that could be relied upon as part of the care arrangement. Bridging ties were contributing as part of the support for individuals, as a way of meeting needs that would not meet the local authority eligibility criteria. As such the results indicate that social capital is probably not reliable as a contribution to the planning and delivery of care.

Traditional elements of social capital, such as family, friends, clubs and society membership all seem to be in place. In this set of interviews, the networks showed a range of community links, although the contribution to support and planning was quite variable.

The results are in line with Putnam's consideration of bridging and bonding ties, with the bonding ties being the ones that are most likely to result in reciprocal support. What is of greater concern is that the most commonly considered bridging ties, employment and societal membership, are now too weak to be drawn on by participants. Overall support towards what would be considered social care from bridging ties is weak and as such should not be considered as a contribution to the personalisation of their care. It is recognised that the participants are all people who have been assessed as eligible for social care. As such some may already have drawn on their social capital to the point that bridging support has been withdrawn. However, the absence of regular engagement with either intentional or appropriable organisations indicates that it is more likely that either the links were not there, or were not strong enough, in order to create reciprocal support.

There is evidence that local authorities have been reducing the amount of support offered, meaning that they provide fewer individuals with support (National Audit Office, 2014, p. 17). The interview results indicated that whilst informal support based on social capital was available, much of it was undertaking support tasks rather than personal care, being consistent with the ONS report (Foster & Fender, 2013). This indicates that support from social networks cannot necessarily be seen as a potential substitute for paid care if the available resources were to be reduced.

Ultimately participants did not demonstrate that they saw social capital as being a discrete part of their support, although some aspects of their networks did offer practical support. This seems to be tied up in societal expectations around when and what type of support individuals can ask for from their networks, an aspect of reliability described by Coleman. This, social capital theorists would pose, requires a common agreement as a society as to what support can reasonably be expected from family and friends (social obligations and expectations), which was not consistent amongst the participants.

Identifying good information on which to base a judgement about the right care to commission is a challenge that all the participants faced. The difficulties that people reported in finding information was a challenge to local authorities. Social capital theorists such as Coleman (1988) identified access to information as an element of social capital. The importance of accurate and reliable information was valued by participants, and was identified as a point to take up with the local authority staff. Coleman's information potential of social capital was not being mobilised, with participants struggling to identify how to plan care efficiently, explore opportunities for innovation or find good information on potential carers.

Lipsky also identified that control over information was a typical behaviour of street-level bureaucrats, where front-line workers used information as a tool to retain their control over resource allocation (Lipsky, 2010). Participants were aware of the importance of information, with an increasing number appearing to be using the internet to find information on services and procedures. This was still in its early stages, but the increased availability of the internet means

that most people will have access either directly or through a trusted part of their social network. Once this becomes embedded the information disparity between front-line workers and the community will reduce and the information giver will become a more important aspect of social capital. Social media offer a new way of networking with people outside of the individual's physical environment. As such it goes beyond information sharing to offer access to bridging ties that previous studies had noted reduced over distance as well as supporting individuals in their relationships with authority. This has the potential to disseminate innovations without the interventions of local authority workers. Whether this can provide an alternative to the use of carer support groups as a vehicle to provide information is not clear, but the weak response to the contribution of support groups indicates that it is worth exploring.

Overall the implication is that a few articulate and well informed people are able to take control of the planning and delivery of their care, but for the majority it is a practice that is strictly limited by the front-line professionals and the organisations they represent – a variation on the risk of cultural isolation, put forward by Bourdieu, made possible by variable quality of individual social capital. What the study was unable to establish at this point was whether that was a result of the capacity of the participants or the way that services were being delivered, although the implication is that the participants' capacity did vary considerably, but the practices did not.

What did come over was that the social networks identified earlier had not been demonstrated to have had a direct impact on the participants' ability to articulate their needs or how they wanted them met. This would imply that the aspect of social capital relating to authority relationships was not being

mobilised. Whilst scope for advocacy is contained within the provisions of the Care Act, it is tightly constrained and would not have been available to the participants of cohort one. It indicates a role for greater peer support, which is not on the government's agenda, or being actively promoted through policy.

Having looked at social networks and the elements of social capital suggested by Coleman, it is worth looking back at the four populations considered in cohort one. The reported networks and elements of social capital did not appear to vary between populations, contrary to the original hypothesis (page 9), either geographically between sites or between older people and those with a learning disability. Indeed, the number of relationships and the reported significance of elements of social capital varied within populations, without any obvious clustering of results. The implication is that each participant was being presented with similar responses by a range of front-line professionals, regardless of the separation geographically and by population.

The data indicates that social capital is not being used to support the personalisation of social care. Aspects of social capital are in place, but they are not being drawn on by participants to support their ongoing need for care. Where support is being provided through social capital, this tends to be through the closer bonding ties and focussed on tasks the local authority would not consider to be part of their role. Given that personalisation was intended to create flexible, innovative care and support arrangements it is not obvious how the individual is going to be able to take this forward without the community based support from aspects of their social capital. This then requires consideration of the role of local authority staff charged with guiding people to create personalised support.

Bourdieu and Coleman advanced the importance of social capital as a disseminator of information, although the appropriate information needed to be present within the network. The study indicates that, in particular, dissemination of information is an issue for participants, a challenge to the enabling model of the screen-level bureaucrat.

CHAPTER 7. THE EXPERIENCE OF LOCAL AUTHORITY SUPPORT

During the interviews the discussion, which initially covered the issues around social capital, then followed the participants to look at a wider range of issues linked to the planning and delivery of their care package. This went beyond social capital and started to focus on their experiences and why it was that social capital did not play a significant role in the planning and delivery of their care. This became a commentary in its own right that brought together issues around policy implementation in public services and the potential implications of the work of Lipsky (2010) on street-level bureaucracy.

The additional information gathered through semi-structured interviews is one of the strengths of the approach, as it gives a voice to those that would not otherwise be heard.

The individuals and how they position themselves according to agency and their imagination determine what gets included and excluded in the story, how events are put together and what they mean. (Larsson & Sjoblom, 2010, p. 276)

As these results were additional to the planned interview schedule the coding has sought to draw out the common themes and is not linked to a specific theoretical framework (table 7.1). This is consistent with the constructivist approach to analysis in which the theoretical perspective draws together the results of the research (Larsson & Sjoblom, 2010).

However, many of the themes do fit within the set of behaviours that Lipsky (2010) attributes to street-level bureaucrats. In this chapter the aspects of particular interest were:

- An environment of resource constraint
- The role of front-line staff in rationing decisions
- Staff control over the environment
- Use of routines and processes
- Professional value base and standards

In this section the role of social capital is very limited, with the main aspects being the relationship the participants had with organisations and authority figures. In looking at street-level bureaucracy the study is seeking to understand the policy implementation environment that inhibits the mobilisation of social capital.

	Participant profile	Resource constraints	Rationing	Independence	Use of process	Control	Delays	Poor consistency of Social Work	Professionalism	Other
Family 1	OAC SA	0	1	4	2	2	1	0	0	0
Family 2	LD C SA	7	1	1	1	0	1	4	3	0
Individual 1	OAS B	0	0	3	2	0	2	1	0	2
Individual 2	LD C SB	0	0	0	0	3	0	1	0	0
Family 3	LD C SB	0	2	1	3	0	0	4	0	4
Carer 1	LD C A	0	0	0	1	1	1	1	0	1
Carer 2	OAC A	3	3	2	6	1	2	0	0	0
Individual 3	OAS A	1	4	0	4	2	0	0	1	1
Individual 4	OAS A	0	0	0	3	0	0	0	0	0
Individual 5	OAS A	0	1	2	0	1	1	1	0	1
Carer 3	LD C B	1	1	3	0	0	0	0	0	0
Individual 6	OAS B	0	1	1	1	0	2	1	3	0
Family 4	OAC SB	0	0	1	0	0	3	1	0	1
Individual 7	OAS B	1	0	2	3	1	0	0	1	0
Individual 8	OAS B	0	0	0	1	0	0	0	0	0
		13	14	20	27	11	13	14	8	10
Participant profile: OA-Older Adult; LD-Learning Disability; S-Subject; C-Carer; A-Council Site A; B-Council Site B										

Table 7.1 Experience of Local Authority Support

Resource constraints and rationing

The study was undertaken at a time when there was a strong public awareness of austerity in government finances. Therefore, it was not a surprise that there was an expectation of resource constraints and the rationing of care. In the coding, the term 'resource constraints' was adopted to refer to themes around the restrictions on central and local government spending, typically around health and social care, whilst rationing was the direct impact on the support they were receiving.

For some the process of rationing was very real, such as with Individual 3 whose care had been reduced from 30 hours/week to 7 hours following a review that he was very unhappy with. In the interview the participant was very articulate about the assumptions that had been made in reducing his support and the response received when he challenged the care manager. In the interview the participant quoted the care manager as saying "*If you continue to argue I might have to do another review, which wouldn't be so generous*". From the interview it was clear that the participant understood that the response was part of a wider reduction in services that was placing staff under significant pressure. The participant spoke of drawing on his social capital, in terms of seeking confirmation from a friend who worked in a local authority, but his response was then based on his Human Capital (Becker, 1993) (see page 54) using his prior experience to formally challenge the authority.

Although the sample is small there was an impression that the approach of the individual to the rationing process was important, as the biggest reduction

was for someone who was articulate and capable of managing a difficult situation (Individual 3). Rationing was not apparent for someone with profound physical and learning impairments, whose carer was presenting as just managing with a bit of a struggle (Carer 3). She recognised the advantage in advocating care concepts that the social worker identified with, such as a model of independence appropriate for her son. This fits in with the concept of discretion in the social work role around who is deserving of state support that was identified by Lipsky (1984) and an example of the relating to authorities that Coleman proposed.

The approach of the care manager for Individual 3 is interesting in a second way as it fits very closely with another of the behaviours Lipsky anticipated when describing a street level bureaucrat (Lipsky, 2010). In the same conversation the participant noted that as a professional he expected to be able to understand the basis of what was being said:

But why, I mean, why wrap it up in sort of legalise I can't understand? I mean I was a senior technical manager in (P) and I just, I struggle with the bureaucracy and the amount of paperwork, and most people are just not able to do it and respond. (Individual 3)

This evidence, that care managers were using processes and jargon to control outcomes, is in line with the findings of Ellis (2007) who was looking at decision making at the point of determining eligibility for services.

The awareness of the arrangements for setting personal budgets varied widely, with some not knowing how decisions had been made (Individual 6) whilst others were looking at ways to improve the level of support on offer (Carer 2). Many of the participants accepted the support on offer although

most would have said a bit more would be welcomed. For example, at 77 years of age the carer of Family 2 was having to transport her to activities most days of the week as public transport provision had changed and, with the participant's deteriorating mental health, was no longer considered a safe option. For many the concept of an elderly carer being expected to undertake these round trips of 20-50 miles, often in the evening and at peak travel times, would be a surprise, but in the context of her asking for a review due to a change in the health of the participant seems a difficult position to justify. As someone that was articulate, sensitive to the social work role and appears capable she was probably seen as presenting a low risk of failure to care and therefore deferred, another aspect of the rationing behaviour of the street-level bureaucrat.

Whilst participants were conscious of the rationing of services some found that, compared with other approaches, it was not always negative. For example, Carer 3 said that compared to children's services the response from adult services was significantly better. Conversely, the prevailing commentary from families' advocacy organisations regarding this transition was the opposite to this.

Yes, and I have to say that again before we sort of moved into the adult service, other parents and things that I was reading on these groups, [] and they're all very negative saying once you go into adult services you know you'll lose a lot of what you had in children's services. Well actually the reverse has been true for us and I think again like you say it's expectations isn't it. (Carer 3)

The collective view of the provision in place was that rationing had occurred in allocating support, which was costing individuals or their families as they had

to make up the shortfall. This is in part explaining the additional support noted in Table 6.4 (see p.126). However, there was limited evidence that this was a source of resentment, rather that, probably because of the current economic climate, it was expected.

Process restrictions, controls and independence

The restrictions caused by administrative procedures were noted by many of the participants. For some this was about limiting changes to the way that care was delivered (Carer 2), for Individual 1 it was to cover poor decision making, whilst for others it was about the local authority monitoring closely the delivery of care and struggling if approaches differed from what they anticipated. For example, Individual 7 described how she would hold onto payments until the invoice schedules matched the timesheets before paying them.

And I used to deduct a certain amount of money off of their invoices when I paid them, eventually. But Social Services found this very confusing because I had to fill out these sheets and they wanted me to fill them out every month and send them back to them about what I'd been paying out from my care for and what have you, and the fact that I was only paying my invoices once every six months, that was the reason I changed agencies because Social Services couldn't cope with the concept of me paying once in a blue moon. (Individual 7)

One of the aims of the personalisation of care was that it should have reduced the bureaucratic control of the delivery of care. That it has come up so regularly in so many of the interviews indicates that administrative practices are still a key shaper of the delivery of care. This control was obstructing Individual 7 from effectively managing the cost of her care and limiting her ability to maintain her independence.

Alongside the administrative restrictions there was a second commentary about the style of interactions, in which participants believed that their support had been overly directed by care managers. For Individual 2 this took the form of directing his residential placements, probably at a time of crisis, whilst for Individual 3 it was about changing his living environment and social activities in order to reduce the level of support required. Given the importance that people were placing on their independence, these actions by social workers are consistent with expectations that actions by local authorities or their representatives would be seen as opportunities to control support.

Reflecting on this and the earlier discussion around rationing it is worth noting Evan's comments on the motivations of one particular group of social workers in adult social care:

'the moral imperative was expressed in terms of the best interests of service users. This principle is perhaps a central commitment of professionalism: the idea of the altruistic, committed person who does not compromise a principle to 'the other' (Bauman, 2000). There is, though, potentially another side to this commitment: the sense of professional patronage and power—the risk of falling into the pattern of 'the deserving' and 'the undeserving'. The danger is that, in the process of determining somebody's best interests on their behalf, the service user is disempowered and demeaned.' (Evans, 2013, p. 754)

The consideration of the approach to rationing did result in the appearance of a decision around those deserving support, meaning that the strong response to control by workers, and the organisational process restrictions, further increases the risk of disempowering and demeaning the service users. This was articulated by Individual 3, and recognised, but not directly stated, by Individual 7.

As noted above, this is a demonstration of the behaviour of a street level bureaucrat as defined by Lipsky, but it is now being seen in a later aspect of the care management process than had been studied in the past (Ellis, 2007; Evans & Harris, 2004). Previously the focus had been on the eligibility decision, but these results show that it also applies to decisions around resource allocation and then service delivery. Where in Care Management the eligibility decision was seen as a key decision point, after which state commissioned resources were made available, within the personalisation process this decision had moved to include the care planning and the decision as to how resources would be used.

Delivery of social work support

Ellis (2011) acknowledged the role of professional values and standards in defining the behaviours of front-line staff. Delays in the support from local authorities were a common theme, raised by two thirds of the participants. For those currently using services it was the delay in reviews of care, even when carers notify the local authority that there has been a change in need (Family 2). Alongside that were the difficulties participants' had in obtaining support due to the apparently impersonal arrangements of the local authorities. At the time of the study both local authorities had implemented a central call handling service, meaning that the initial call was taken by an unknown person; the participants clearly did not feel comfortable that the person they spoke to had access to sufficient knowledge to handle their contact appropriately.

The impersonal nature of the service continued with two respondents (Individual 1 and Individual 6) commenting on specific interactions. The interaction Individual 6 had with the hospital social worker was of particular note as he described not knowing who was managing his discharge, an exceptionally lengthy process to achieve this, and issues with ward staff about retaining contacts that would support his ultimate discharge (see page 133). With organisational structures that distance front-line workers from the citizens they are meant to be supporting it is not surprising that, with the exception of one case, social workers were not seen as part of participants supportive networks in the way that care assistants were.

In his update on street-level bureaucracy, Lipsky (2010) reviews his position regarding the front line staff with a professional role. In this he considers the expectations of professional codes of conduct and the additional tension on front-line workers. This is specifically studied by Evans (2011) where he sets out different responses to this amongst social workers. He described how some staff continued to follow a legal and professional code based on the traditions of social work, whilst others had aligned themselves to an organisational rules approach linked to managerialism and performance management. The results of this study seem to indicate that in this sample it was the later culture that was pre-dominant.

As managerial standards were being promoted it is not surprising that some of the participants in the study are reporting behaviours that conflict with professional standards. As a former social worker, the carer of Family 2 felt that the prevailing approach now was administrative and did not value or make use of the skills of the front-line staff. There are arguments for both

approaches, but in deciding the way forward there does not appear to have been a dialogue with the wider community about the type of service that they expect to see delivered, with the space currently being filled by a managerial culture.

Conclusions

The extension of the study based on the interview data brought the discussion into a consideration of Lipsky's concept of street-level bureaucracy (1980) along with a discussion around the national approach to austerity and its local experience in the rationing of services.

Overall participants were aware of the national drive for austerity and were sympathetic to the position this placed local authorities in. Where there were tensions this was about the need for a transparent approach to changes and that decisions were seen to be fairly implemented. This is consistent with the findings of West (2012) where the studied authority were criticised for confusing austerity with the transformation agenda.

When looking at the organisational culture being presented the participants described it as being procedural, administrative and typically impersonal. The structures developed to create administrative efficiencies, such as centralised call handling and allocating staff for specific tasks, were seen by participants as a poor service that often failed to meet their needs. There were frequent delays in services that, along with the performance management dominated culture left the participants feeling undervalued. Given that overall perspective it is not unexpected that, unlike with care staff, the social worker or care manager was not seen as a valued or core member of the support network.

The final element of the data was around the delivery of support by local authorities. In this there was significant evidence that was consistent with the concept of street level bureaucracy and that the risks associated with this, around professional control, managerialism and impersonal, poorly delivered services, was a factor in the lives of most participants. Social capital theorists would propose that, through social capital, individuals would be able to access the information and self-confidence necessary to assert their needs as a balance to the organisational and professional agendas. In practice this was not being seen to happen as people reported a lack of information and the control of decisions, in practice, being with local authority staff.

Reflecting on the implementation of the NHS&CC Act in 1993, the same issues were becoming apparent as empowerment and the transformation of service planning were not happening at an individual level.

The interviews with the second cohort were therefore designed to understand why social capital was not being accessed, what the impact of the professional role was on supporting people to access their social capital and what this indicated in terms of the transformation agenda for adult social care. It would also look at the reported behaviours of local authorities and their staff to understand what has influenced the implementation of personalisation as a policy.

CHAPTER 8. THE LOCAL AUTHORITY PERSPECTIVE

Introduction

The previous chapters demonstrated that whilst participants had many of the elements of social capital, there was no evidence that it was being stimulated to either create an additional resource to reduce the level of services commissioned by the local authority or to provide information and knowledge to support innovation and flexible personalised approaches to care and support. Additional data, provided by participants, indicated that there were factors relating to the culture and practices of the local authorities which implied that the delivery of a transformed, personalised service would not occur without significant changes.

The Care Act had a clear vision that a person's social network should be considered as a part of the care provision, based on a definition of social capital working through individual transactions as described by Lin and Coleman (Lin, 1999). To support personalised services, individual social capital should be offering access to resources 'embedded in social networks' (Lin, 1999). As noted in the literature review this is a narrower concept of social capital compared to the common usage in the personalisation narrative.

Following the interviews with participants receiving support the consistency of their experiences indicated that there was a need to consider the perspective of staff at different levels in the two host authorities. This was to test out the findings around how local authorities sought to recognise social capital, their perception of who had control and were the decision makers that supported

innovation in care delivery, and the additional earlier findings around behaviours described as street level bureaucracy. From this was drawn a range of conclusions around the impact of social capital, the issues for local authorities in supporting people to access it and then some wider issues around policy implementation in social care.

	Host 1		Host 2	
	F	M	F	M
Service Manager	1	1	1	
Policy Officer	1		1	
Team Manager	2		2	
Social Worker	1	1	1	1

Table 8.1 Cohort 2, sample profile

Table 8.1 shows the spread of staff employed in each authority that participated in the study. The only gap was a service manager role in Host 2, where the post was vacant at the time of the study. This resulted in thirteen interviews overall.

Unlike in cohort one, the results from cohort two did differ between each population (social workers, team managers, senior managers and policy officers). In reporting the findings, the issues relating to social capital are considered followed by aspects of policy implementation and then the implications of organisational governance in local authorities.

Accessing social capital

Awareness of social capital

The awareness of social capital as a term was variable, with some participants not being aware of it, but all being familiar with the elements of the concept when it was described.

Using the specific term, I think no-one uses the term but the elements of, in terms of the exchange and community networks, what support a person has within their home, their own capacity and their relatives, (Social Worker 3)

Looking at the elements of social capital, participants were very aware of the need to identify the immediate social networks around the person, although the focus was on what daily living tasks were undertaken. There was no evidence that participants used a consistent approach to assessing the value of these networks or their reliability. How staff assessed the value of networks was not articulated, but the implication was that it was often based on cultural assumptions, not any form of verifiable assessment. This led to the prioritisation of immediate family links and the traditional concept of 'next of kin', although neither has a legal position unless the powers of the Mental Health Act 1983 are being considered.

The interviews did consider the information potential of social networks, in particular to support innovation. Where this happened participants were willing to support the person on a reactive basis, but not a proactive one. The indication was that participants were aware of the potential of social networks contributing to the support of the individual, but that it was not something they sought to stimulate.

However, in many of the interviews participants did confuse natural social networks, specific to the individual, with community networks that were set up to meet a range of needs in the community e.g. the village transport scheme identified by Team Manager 1. In terms of the study this was significant, as the focus had been on individual sources of support that would develop without the intervention of state organisations, whilst the community networks

being described were organisational responses that the state agents were seeking to promote or develop through social entrepreneurs and were not necessarily part of an individual's historical network. Where they, rarely, offered an element of social capital this was as bridging ties.

Some of these arrangements did relate to social capital, in that they were driven by local networks, including arrangements where support is gained through membership of a community, such as a local church, and would fit in the definition of social capital, probably as appropriable organisations. Many local groups now receive public funds (in the form of grants) in order to provide support to a wider aspect of the community, in effect as a paid service provider, even if the people delivering it are not remunerated. The lack of bridging ties and reciprocity would indicate that they are not part of an individual's social capital.

In the second cohort interviews, participants were describing community organisations as part of local social capital (mainly intentional organisations) in a way that was not being recognised in the responses of the first cohort. This highlights the value in separately recognising the role of social capital, community capital and the action of social entrepreneurialism in developing them (see p.47). Whilst individuals may take advantage of the support offered by community organisations, it is the ability of social networks (social capital) to invest in the wellbeing of the individual (the reciprocity aspect) that makes this source of support different.

Having established that participants understood the elements of social capital, they were then asked if they were aware of social capital having been

discussed as part of their role in the authority. Amongst team managers and service managers the response was generally no, although both the Care Act leads and three of the four social workers said yes at some level. From the discussions there was evidence that the contributions of social networks were considered alongside the implementation of personalisation, but had then ceased until the planning around the introduction of the Care Act in 2015 brought them back into consideration.

It hasn't been actually a formal discussion but it's something we talk about all the time. (Social Worker 4)

The team managers and social workers tended to see the engagement of social networks as good practice that they should be promoting as part of their professional role, whilst the service and policy managers were inclined to see them as a potential way to manage demand. For professional staff the contribution of social capital was about maximising the potential quality experience for the person being supported.

It's always nicer to use friends and family as it is opposed to paid care to take you somewhere. (Social Worker 2)

For managers it was recognised that the benefits in accessing social capital would be that some support would be delivered at no, or reduced, cost to the authority and substitute for some paid care. Team Manager 1 gave an example of how a rural community supported each other with transport which would otherwise have become a cost to the public purse; although the example better fitted the concept of community capital rather than social capital.

This is evidence of the different managerial and professional cultures previously identified by Evans (2011), with social workers and front-line managers identifying more with a professional value base and standards than with the process and performance management one.

Several participants discussed the issues around the identification of an individual's social capital with limitations being imposed by the role bounded perspective of the assessor, or the service user not recalling the support they get from their network. The identification of social networks by social workers had to be completed as one part of the assessment process, which they all recognised as being a time constrained exercise. This limited assessment of social networks and their contribution was mentioned by both a team manager and a service manager as being something they were picking up from reviewing case records; that otherwise appropriate assessments were not compelling as there had been no consideration of the role of an individual's networks.

Assessing social capital

To be able to engage an individual with their natural support the social worker needs to have the appropriate awareness to identify it. The results of this were mixed in that practitioners tended to report that they were sensitive to individual networks, but equally they did not present convincing evidence in terms of case examples to show how this resulted in better services. One team manager commented:

I think we haven't quite grasped the concept of personalisation, I don't think we're using it to the best of its ability because we know it's there, it must be because what we do for people is

quite minimal, the formal bit, so that there's this whole safety net of support that we know is there but we can't somehow formalise it and document it and acknowledge it, if that makes sense. (Team Manager 2)

The context of this observation was a woman of 101 living alone and being supported by her daughter in the next street. Whilst the practical support was limited, it was the perceived security and emotional support that maintained her in her own home. The initial screening assessment did not recognise this. The complexity of social networks can be such that it is very easy for both carers and professionals to miss the reality of the support being provided, that the emotional support of a family carer living in close proximity maintains an otherwise unsustainable provision. This accounts for some of the difference between the eligible support and the actual support provided in table 6.4 (see p.126), particularly for Family 1 and Carer 2.

The Office of Public Management (2009) paper set out a basic approach to assessing the role of social capital in care. In each interview workers and managers were asked about their approach to identifying social capital and there was a consistent response that no framework was in place to guide workers.

Both team managers and social workers also said that they believed that some people sought support from social care services because they had little or no social capital. This specifically related to people with a learning disability who had complex care needs that were placed in care homes as they were otherwise considered to be isolated in the community. As such they had sought to assess the individual network but had not found appropriate support.

The implication is that at various levels local authority staff are aware of the potential of social networks, but that in assessing this there are variations in the way that they are being recognised. Whereas the interviews with people using services indicated that those in care homes had an element of social capital this was not necessarily recognised in the care assessment when it could have had a benefit to the individual. An example from Service Manager 1 was when a placement was being considered and decisions were being taken with a single family member without recourse to the individual or his wider network that would have pointed in a specific direction. Making the wrong placement would have resulted in the individual losing contact with long standing relationships that continued to matter to him prior to the placement. The background to this became clearer when staff were asked about the way that networks were recorded.

Recording of social networks

Whilst there has been consideration given around the impact of recording systems in social care (Evans, 2013) it was a team manager that succinctly stated:

*“we don’t document it, we don’t audit it, we don’t count it.”
(Team Manager 2)*

This is a good reflection of the position that Buffat (2015) outlines, in that managers in screen-level bureaucracies align with the performance management approach that favours quantitative data above the qualitative experience of front-line staff.

What was also being reflected upon was a general concern held by many participants about the electronic recording systems in place. Whilst in themselves an administrative tool, the bureaucratic processes that front-line staff are required to complete can be shown to have an impact on the way that they practice (Evans (2013); Bovens & Zouridis (2002)). Means et al went further to note in 2001 that:

The harsh reality was that numerous social services authorities developed care management systems based on the devolved purchase of services with completely inadequate IT and information system back-up. Inadequate IT systems also continue to pose substantial barriers to the exchange of information between agencies. (Means, et al., 2008, p. 66)

Since all case recording in adult social care is managed by corporate database systems, any identification of social networks or social capital needs to be captured within the database if it is to be mobilised.

The two local authorities were using different database products provided by mainstream companies. One was using a legacy product that had some changes introduced by the manufacturer to deliver Care Act compliance, although the interviews indicated that local revisions were also being developed. The other was using a recently introduced database that was designed to be Care Act compliant using upgrades released in February 2015. Whilst the interviews had not specified the format of the database, it is reasonable to assume that the Care Act upgrade would have been implemented by November 2015 when the interviews were held. This underlines the importance of the issues that Bovens and Zouridis (2002) reported, that the systems in place defined the processes implemented by front-line staff.

It is notable that the responses from staff were influenced by the available database, with staff using the older system reporting that it was not capable of holding the detail needed to accurately identify potential social networks, let alone social capital. The database is able to record the details of interested parties, but not identify the quality of a relationship or what they can offer in terms of support. The only option would be to record tasks on the care plan as being undertaken by informal carers, which would only occur if it were seen as an eligible need. Given the estimated position outlined in table 6.4 (p.126) much of the informal support would therefore not be recorded. However, one participant indicated that typically it was only the direct family that were recorded (Social Worker 1). The Care Act compliant database was seen as being able to capture a better amount of detail, although one respondent noted that this brought with it the commensurate increase in pressures due to the time required to enter details (Social Worker 3). This would appear to be an example of the enabling approach (Buffat, 2015) as practitioners and software developers seek to promote the social work task, although the slow progress of this development also led to frustration amongst staff and managers.

In addition to the recording of social networks, participants were also asked about the potential to record differing perspectives held within the individual's social networks regarding a situation. It was not possible to identify how this would be recorded other than as a single view. As a compromise the suggestion was that it was likely to be a consensus based on meeting family members, but without any way of noting the presence or range of dissent in the network (Social Worker 1).

Although social workers and managers were aware of the difficulties of family dynamics and history, and that this meant that some families had limited involvement, there remained a bias towards involving the immediate family in decisions. The provision of the Care Act to involve key members of an individual's network in the assessment was raised by social workers in one area, but it was not clear from the interviews how the authority's information systems had been developed to reflect this. As a result, it is the collected view of the family that is likely to be predominant in the record, regardless of the position that they hold in terms of the social networks of the individual.

It was a senior manager that said that the database they used hindered good recording and that the staff '*hate it*' (Service Manager 1). This is a significant risk as the purpose of the database system is not only to record the eligibility decision, but also to support the ongoing provision of care and to consolidate and present a range of information where more than a single social worker is involved in assessing, planning and commissioning an individual's care and support.

Whilst any information system is only a tool that is used to deliver a function the interviews indicated that, in terms of capturing and describing social networks, the use of the available databases was still falling short of delivering sufficient detail and subtlety to support the assessment of vulnerable adults. This fails to deliver on the enabling approach Buffat (2015) described in screen-level bureaucracy as being the goal for this type of service. These databases fail to sufficiently recognise the value of social networks which can then be used to inform the planning and delivery of care and support. It is only the ongoing relationship between the assessing social worker and the

individual that can make it possible for social capital to be utilised. Indeed, a team manager (Team Manager 2) was able to describe the way that an individual was supported in the community, with minimal state support, but which was not recorded by the social worker. When the care agency cancelled a weekend's cover, the council social worker on duty (i.e. not the usual worker) made a range of interim solutions to replace that support. Had the network been detailed it would have been clear that these arrangements would not have been required. Whilst in this case the result was over-provision, the risk is that a failure of the informal support may have a significant negative impact that the authority would not be aware of.

The interviews gave a strong indication that whilst the recording systems may have been able to record the legal aspects of the workflow required to support care delivery, they did not capture sufficient detail of potential social capital resources to allow this to be noted as a contribution to a person's support, or to be able to capture it as a valued aspect of the support being delivered. Indeed, where the aim of personalisation was to place the individual in the centre of a network of support of their choosing, the systems have not been developed sufficiently for them to be a tool to support practitioners to deliver this. Whilst Buffat (2015) defined the approach of ICT as either curtailing options for citizens to create a transactional service or enabling professionals to develop a service round the individual, the evidence from the two authorities was that in both the approach to information systems were curtailing the collection of information and then using the results to inform a qualitative judgement of need. In failing to take either approach the vision of

the purpose of the systems is compromised and fails to be valued by those using them.

The future of informal support

Social care, and the total public sector, need to be seen within the wider financial environment effecting the community, with wages having reduced in real terms between 2008 and 2014 (Scrutton, 2015). As a result, people are having to spend more time on their own needs, working longer to receive the same income, and less unremunerated time on other people:

As people have become less economically secure, they have tended to turn inwards, focusing on just getting by from day to day, with no time or energy to connect with others or take local action. (Slay & Penney, 2013, p. 5)

At a time when vulnerable people need support from their networks to compensate for the reduced public services, the implication is that this support is also likely to be withdrawn. This appeared in two interviews with the social workers:

I think it would be difficult because of the specific economic conditions I think family won't be able to spend that majority of time with the disabled relative by providing informal support and so on so that is a barrier there. (Social Worker 1)

I think people will rely more on their families and communities but then those people if they're still working age they're going to have to be working so I don't quite know how it's actually going to work. (Social Worker 4)

Whilst professionals and public discussion has focussed on the impact of the austerity policy on the delivery of public services, little attention has been given to the capacity of social networks to fill the gap in provision. The

literature and interviews indicate that the weakening capacity of social networks could become a risk to vulnerable individuals, particularly those who have limited engagement with professionals monitoring their overall wellbeing. In the past failures in public service provision may have been compensated for by social networks, a situation that can no longer be relied upon.

Choice

Any limitation on choice is significant as, without a structure to create space for the mobilisation of social capital, the bureaucratic model of Care Management will commission a service that makes no allowance for social capital in the planning and delivery of care. The scope for choice in the delivery of care creates the opportunity for the individual to adapt the way that care is received and is personalised to them. In doing so the individual is able to give appropriate priority to the delivery of support from their network and bring in knowledge and skills that enables them to optimize their lifestyle. Without access to choice they will be receiving a productionised service that replicates the same as what others receive.

This is consistent with the experiences reported earlier by participants in the first cohort. Based on those interviews I had anticipated that choice was going to be a tension for social workers and managers. The social workers and team managers were clear that, whilst they tried to promote choice, in practice there were restrictions in terms of the support they were asked to arrange.

Both local authorities have a long history of commissioning the majority of their support from independent providers, meaning that in each area there is a mature market of competing agency providers. As resources for care have

been reduced since 2010 (Jackson, 2015) both authorities have responded by seeking more efficient solutions. One solution both authorities have chosen to follow are procurement frameworks, which offer a restricted number of providers an agreement that specifies costs and service standards. The aim is to create sustainable low cost services without compromising on service quality. This is a limitation of choice as the frameworks do not cover the whole market. In Site B for instance, in 2011 the framework included seven agencies out of a total of 64 registered with the Care Quality Commission in the area. Only if there is no capacity are providers outside the framework offered contracts, which is often limited to services for an individual.

In the interviews the social workers spoke of directing people towards framework providers or, in Site B, the outsourced local authority service (Social Worker 1). This was seen as supporting the authority to efficiently manage resources. Later in the same interview the participant discussed the services being received, that the satisfaction with the provider was not high and that they were aware that people had indicated a preference for other providers. How people were supported to achieve this alternative preference, in line with the Care Act guidance, was not clear, but the option of having a direct payment was suggested as a route to achieve this. This approach to using direct payments was cited more in one local authority, by staff in both learning disability and in older adult services. In this environment, with the user having little opportunity to influence provision, there is no clear space for the regular mobilisation of social capital.

Another common theme was that social workers in both authorities suggested that some people did not want the responsibility for selecting their own care, and as such asked the social worker to arrange it for them.

Quite a few of them just want you to kind of, they're calling us at a point of we need help then we need to go in there and provide carers or yes, sort it out basically. Or I need respite and sort respite out. So sometimes it may be an initial review or a later point where the initial crisis has calmed down that you may start thinking a bit more, talking about what else might help improve the situation once you've got the initial, not always a crisis crisis, but you know not a good situation, sorted. (Social Worker 4)

[...] decisions should have been taken by the individual with the support of the family network. We encourage them. I think, 60 – 70% of people get that support from the family and they do make the decision and 40% will always rely on the professionals to make their decisions for them. (Social Worker 1)

The second quote is in contrast to the results of the interviews with participants using services, where the indication was that social workers tended to direct who provided the commissioned support, table 6.6. There is therefore a difference in perception between the group of social workers, and the participants using services, as to how open the care decision really was or how bounded it was seen to be. Where social capital is being effectively mobilised there would be evidence of service users challenging or advocating for alternative approaches to service delivery. There was no evidence of this from either cohort indicating that individuals are not drawing on their social capital to understand how to make best use of contacts with local authorities.

Both authorities had adopted a model whereby a team within the contracts and commissioning function sought services from the market in accordance

with the assessment of the social worker. Both authorities had reported difficulties in the past with capacity in the independent sector, so had centralised the allocation of capacity as it became available. This was seen to be more efficient than each social worker phoning round agencies as required. However, it then takes the choice of provider away from both the front-line worker and the person receiving support.

In the first cohort interviews, only one of the fifteen participants was not using service provision based on a traditional model. Along with the very limited number of examples from front-line staff of innovations that did not use traditional services, the indication is that people do not routinely use personal budgets to innovate in the way they receive their care. From the interviews with staff and the users of services the common theme was that the concept of choice was very bounded by the service users' assumption of the control held by professionals, the realities of local authority resources and the procurement strategies that sought to make services available. This is in addition to the traditional market principle that choice is only ever between the available offers at the time of the transaction. The result of this is that the final offer to the individual is likely to be limited to only a single offer or even none at all, which Individual 6 identified.

In this environment there is no clear space for social capital to have an impact on the choice of care provision.

Innovation

Each participant was asked to give examples of innovation in terms of service planning or delivery. This was a test as to whether the information potential of

social capital and the ability to relate to authority (Coleman, 1988) to create a personalised service was being recognised and utilised. In the interviews with the first cohort attention was given as to how participants gather information that would support them developing services that were different to the traditional agency model. In the second cohort the interviews sought to identify innovation and to then explore how this was enabled by front-line workers. The assumption was that the knowledge to support innovation would come either from the front-line workers or through the social capital of service users.

Whilst the team managers came up with examples, the social workers found it hardest to describe appropriate situations. It was Social Worker 3 that spoke of innovation being restricted by layers of policy.

Yes, absolutely. [...] I was thinking of the mind-forged manacles as Blake would call them on policy, you know William Blake the poet. It's very much there's a lot of mental effort in negotiating risk, rights of choice and the exact scenario that you described, we often court in our mind actually and I think in that sense you just add layer and layer of policy, you just, you're going to get more entangled in it all...(Social Worker 3)

From the interviews the impression given is that whilst innovation is described as being encouraged (Team Manager 3), in practice it is not being driven by front-line workers, rather it is based on exceptional situations around individuals and then endorsed at a management level. In the interview with Social Worker 2 she outlined the tension between allowing more flexibility in the use of personal budgets and the precedent it would create that could lead to less control over resource allocation. For example, in allowing one person

to include household tasks such as cleaning, more people would want this and the demand would exceed available resources.

if we're not careful do we not run into a society where every 90 year old or every 60 year old if you like say's I can't be arsed to do the washing anymore, or every person who's alcohol dependant says I can't do my washing. So we put a cleaner in through direct payments. Yes it will meet his need, yes he can sleep while the carers doing it. I don't know, I don't know if it always sits right with me. I think it's, there's a fine line that you've got to meet the needs of. (Social Worker 2)

This decision not to allow flexibility was not considered to be something that would go back to a manager for discussion. For an innovation to be supported it appears that it would need to be related specifically to activities the local authority would consider itself to be responsible for, which is a decision that needs to be confirmed by a manager.

There was a noticeable culture of risk aversion amongst staff in both authorities with practice being justified by following procedure more than professional values. This is consistent with Lipsky's (2010) work in which he describes the front line as being under sufficient pressure so that there is no capacity to support innovations seen as being time consuming and of no benefit to the front-line worker. Senior managers were keen to promote innovation, although mainly as a management response, but recognised that the need to implement a new model alongside managing existing demand meant that it was something few staff were able to pursue and rolling out small schemes across departments was a significant challenge.

These results are consistent with the commentary from the first cohort participants, with strong individuals discussing innovations they have done, or

could follow, with no active support from the local authority staff they are in direct contact with. The interviews showed that innovation was not being actively facilitated by workers, neither was there a body of evidence in practice that showed that individuals were innovating as a result of their social capital. Observing attitudes amongst council staff has shown that the current approach to commissioning support has not enabled people to access social capital to support innovation in the delivery of their care.

Information on services

The lack of good information on services, and how to access them, was a strong message from the first cohort participants (see Table 6.5). Using Coleman's criteria for social capital the ability of the individual to access information on social resources, either directly or through their social network, was seen as important to good decision making around their care and support. The second cohort participants were asked about this and agreed that the current information offer was not good, although offering a variety of perspectives on this. One spoke of the difficulties around setting up and maintaining a central record, giving an example of having done this as part of the implementation of personalisation, but it then lapsed as providers were not updating their information and the authority not providing an on-going resource to pro-actively maintain records (Policy Officer 1). Partly in response to the new duty in the Care Act, both authorities were in the process of renewing their arrangements, although these were both focussed on creating a record of services. There was no evidence that this information also included guidance on how to access services and what to expect in terms of the management of support. Both authorities were seeking to develop their

offer and had engaged with commercial partners to deliver this. Neither was fully developed and one in particular did not expect to see results impacting on residents for several years.

Working with the regulator, the Care Quality Commission, it is possible to maintain a record of regulated services – those that are typically commissioned by public bodies. It is the community and network based support that is not easily captured, and is often very local in its impact. In social capital terms this is the bridging ties linked to appropriable and intentional organisations. It is these services that offer support outside what the local authority commissions and which contribute to the individual's quality of life.

Both host authorities had arranged for a central provision of preventative services to include information on a range of council and community activities.

I don't know if you're aware we have prevention and assessment teams. So they are people, they are a team, multidisciplinary team, health advisors as well as social care staff from the voluntary sector who work with people who are deemed not to have eligible needs. They don't actually, I mean they provide advice and information and help, will help people set up services so it's obviously from its name about early intervention and getting in there and giving [...] advice and support to people about services that are out there. (Team Manager 4)

The description indicated that community support was part of a prevention agenda, but that, once eligibility had been established, ongoing support was expected to come from commissioned services. No participant specified that the resources available to the prevention team were not available alongside commissioned services, but only Social Worker 4 spoke of using universal

type services within support arrangements. Whilst the users of services sought a mix of support from family and other networks, once eligibility for support had been established the professional expectation was that services would need to be commissioned.

Knowing what support to expect and what was available was a clear issue for people needing support, although where that support came from was not an immediate concern. The responses from the councils were to offer information as a gatekeeping exercise, to keep people away from direct contact with front-line staff, but not to see it as a way of reducing demand by actively promoting a range of services to people eligible for support. As such there appears to be a difference in expectations between the two groups, which neither appears to be aware of. This is in line with the literature around the risks of top-down policy implementation as there is no clear link between the development of the information offer and the expectations of people seeking support for the first time.

Policy implementation in social care

Local and National Policy

Participants working for local authorities were asked about the impact of policy on the understanding and awareness of elements of social capital. The response was consistent in that, whilst it was not addressed as a specific concept, it did run through aspects of policies on assessment and personalisation and had become more prominent recently as a response to the Care Act. Reflecting on the aims of the Care Act one manager responsible for its implementation said that whilst the policy intention was for

councils and workers to be more nimble, it was the bureaucratic nature of the organisations that hindered the realisation of the potential of social capital (Policy Officer 2). There was also the view that:

National policy doesn't help because it never defines anything. It's always completely full of vagueness as I call it. They will say we want you to do but we're not going to tell you how to do it, you can interpret that. (Policy Officer 1)

It is this need to interpret that creates the space for policy implementations to move away from the intention and is a key criticism of the top-down approach. The participant goes on to consider the response of staff, noting that they frame their work by reference to statutory guidance and case law. Team managers and social workers such as Social Worker 4, whilst recognising this factor, were also describing their practice in terms of their professional values and behaviours. This supports the final conclusions of Ellis' article

'In this article, the author has attempted to demonstrate that frontline decision-making represents a dynamic interaction between the countervailing forces of top-down authority and street-level discretion, the precise characteristics of which in any given policy field can only be determined through empirical inquiry.' (Ellis, 2011, p. 241)

In observing this tension between policy implementation and professional practice it confirms that the initial observation from studying the first cohort of participants, that social workers had been acting as street-level bureaucrats in the planning of care, was still current. Indeed the continued role of professionalism was recognised by Lipsky (2010) in his revision of his initial work and by Ellis (2011), as the delivery of social welfare changed and started to revert back to a service based on individual skills and professional judgement as much as managerial and administrative control.

In changing back to a professional model two of the senior managers expressed a concern about the skills of the existing workforce, which had been developed as a resource management service and was now being asked to do something different.

*And the model they use, and the progression model is very, it's very a social work model, but we actually really struggled to find people to second to the team with good social work skills that can do that work because we haven't got enough skilled, qualified social workers, even in the younger adults area, to do that. And that's quite frightening really. And I think that's one of the things, it's about training and experience. It's not there.
(Team Manager 1)*

*But unfortunately a lot of people haven't been trained to do real social work, or if they were it's been very much flattened down by the expectations of what care management was about.
(Service Manager 1)*

Whilst the policy guidance was consistent with professional standards, and local training sought to promote this, the reality was that it was the start of a culture change that managers expected to take a long time to realise. The interviews with front-line staff supported Evans' (2011) conclusions that there was a body of staff already willing to identify with a model based on professional standards and values, but that the participants receiving support (Chapter 7), said that the reality was still a long way from their current experience.

When looking at the awareness of social capital amongst front-line staff the participants described it as a professional expectation rather than a managerially led process. The lack of an acknowledged working definition for social capital in the policy implementation at both national and local levels has meant that it has not been specifically developed as part of practice. Some

participants recognised that this may have been mitigated by including it in professional training, but the reality was that most staff were not sufficiently aware of social capital to be able to make it real in practice.

Aspects of Street-Level Bureaucracy

Part of the rationale for the second cohort was to look at whether staff were acting as street-level bureaucrats in the arrangement of care and support, that is after the eligibility decision. What the users of services indicated was that, whilst the eligibility decision that Evans & Harris (2004) and Ellis (2007) previously considered was a key organisational decision, for the individuals it was the decision about how and who provided their care that was most important.

Lipsky set out an environment that encouraged the behaviours of a street-level bureaucrat, including the need for resources to be financially challenged, that allocative decisions are made at or close to the front-line resulting in front-line workers having discretion in allocations and the bureaucratic organisations focus on standardised roles and performance monitoring. This needs to be happening in a policy environment that is politically led and ambiguous resulting in conflicting organisational, social and professional motivations.

It is not surprising that at all levels in the two organisations participants were conscious of the impact of limited resources.

There's a lot of pressure around [...] resources, budget constraints, significant financial issues, and I think that kind of squashes that kind of discussion [about social capital] because actually the focus is around actually managing demand,

performance indicators, and managing the budget. (Service Manager 1)

The service manager is clearly articulating the issues faced in that the financial environment has a strong influence over the allocation of resources. The result is that as Social Worker 1 observes there is a strong organisational pressure to use a particular provider, as it is supported by an agreement to purchase a pre-determined level of services, despite the services being less popular with those to whom they are allocated and that those that are capable of changing providers tend to do so. A similar effect was noted in terms of the allocation of other services commissioned directly by the council on behalf of individuals. This indicates not only that organisational motivations are leading service provision, but that they are also controlling the direct allocation of resources. The lack of flexibility leaves minimal scope for innovation and therefore no role for social capital in creating personalised services.

When considering initial referrals for support one participant noted:

..... so there will be a judgement there of are we going to open the gate to this person to LD services or not [.....] And to be honest that can be quite arbitrary. I can think of persons who've got into a service at one point and maybe on another day another person might not have (Social Worker 3)

This clearly sets out the difficulty front-line workers have in applying an eligibility criteria consistently to individuals with a range of presenting needs. Whilst organisations and policy initiatives have sought to better define the criteria, front-line workers are still using some discretion as to how it is to be applied.

Managers did reflect back on the procedural nature of care management and how it had made decisions clearer, but had not been responsive to individuals needing support. It was described by Service Manager 1 as being a traditional restrictive model, although they noted that the current move towards social work methods was actually a return to the situation prior to care management. In the final comments from Team Manager 3 they noted that the care management approach could be described as a street level bureaucracy, and something that needed to change if a personalised service was to be delivered.

Social Care and Austerity

Having had up to nine months to consider the implications of the Care Act, the council staff did reflect on the difficulty of implementing new legislation at a time when they were also being asked to implement significant financial savings. In 2011/12 both authorities made substantial reductions with one reducing the social work capacity by 25% and the other re-assessing every service user in order to reduce service packages against a tightened eligibility criteria, with a target of limiting overall spend by 20%.

The result for staff was that they were very conscious of the need to restrain spending either in terms of eligibility for services or subsequently what services people were facilitated to purchase with their personal budgets. Team Manager 1 and Service Manager 1 both spoke of the need to change the culture of social work to focus on strengths and abilities rather than the prevailing deficit model. This focus on strengths informed the approach to assessment in the Care Act (SCIE, 2015) and is seen as an opportunity to

maximise the resources drawn from the community as both social and human capital.

Equally the first cohort participants were also aware of the overall resource constraints and that it was an element of the decisions made by the front-line staff. It is hard to reconcile this commentary from front-line staff and service users with the ADASS position that there had been no reduction in the quality of care (Jackson, 2015). It may be answered in part by Wallace:

‘The withdrawal of the preventive services I referred to earlier was very challenging; however, we saw staff and service providers managing funding reductions in a way to protect frontline service users by withdrawing gradually.’ (Hardy, 2015)

This also highlights the question as to whether the respondents were considering the quality of the service being delivered or the quality of the experience of receiving care – one is about delivering a good interaction regardless of the impact, the other is the overall impact services have. It is likely that it is the quality as defined by the overall impact of services that is influenced by reducing total provision, as reported by Individual 3.; the quality of care may remain for the services that were retained. Indeed, Lipsky notes;

‘For public officials the problem of managing the fiscal crisis consists of reducing expenditures while minimising the apparent impact of the cuts.’ (Lipsky, 2010, p. 173)

This environment is not conducive to front-line practitioners seeking to be innovative or taking risks around new service approaches. The interviews noted that practitioners were not inclined towards innovative approaches and the senior managers were struggling to support projects that tried to change

the current service framework. When looking at bureaucracies that were subject to financial pressure Lipsky records:

'If in other times social services, for example grew in response to perceived societal needs, in a fiscal crisis the imperatives for service development are subordinated to the demands of perceived revenue limitations.' (Lipsky, 2010, p. 172)

The responses of the managers in the study indicate that for them managing the financial environment (delivering the policy of austerity) was seen to be of greater significance than embedding the infrastructure to support the delivery of personalised services. This would include making space to identify and mobilise individual social capital.

Whilst Lipsky's work was based on limited numbers of organisations responding to state level issues, the common responses from the two host authorities, along with public comments from managers quoted in the press, indicate that a national crisis, such as the one that started in 2007, has had a similar effect across a national tier of organisations where they all face the same triggers.

Organisational governance

Both local authorities had adopted similar organisational arrangements in order to deliver services. Preventative services such as information giving and community development were being arranged within a community orientated directorate; the arrangement of social care was accessed through a central call centre, which screened for initial eligibility before passing on details to care management teams. Both authorities had specialist teams for people with a learning disability that had their own selection criteria. Following

assessment, the intention articulated in the personalisation model set out by In Control was to have had independent care brokers supporting people to arrange their care, but in both local authorities this did not prove to be sustainable, with the care brokers not continuing their services. As such some social workers supported people to arrange their own care, but many people who asked for a local authority managed care package had this passed to a central commissioning team whose responsibility was to allocate available capacity and to monitor the quality of services provided. These teams were developed from the commissioning function and did not appear to be designed to work to a social work model.

we actually do the assessment, pass them on. If it's a community care package. And we pass that on to our monitoring and payments team. So we don't actually get, unless it's a personal budget we don't get involved with commissioning the care agency to do the work. That comes from our finance team. (Social Worker 2)

This approach may have been based on the delivery of replicable services using staff with a specific skill set, that was informed by what Osborne *et al* (2012) described as a manufacturing paradigm rather than a service process.

'This has generated a "fatal flaw" in public management theory that has viewed public services as manufacturing rather than as service processes – and that are created by professional design and input and then delivered to the user.' (Osborne, et al., 2012, p. 136)

In listening to the experience of the users of the services there is a need to review the governance of the service. The interviews established that the management of information by the database systems available to staff were not able to fully record the experiences of individuals or the networks around

them. As such it was individual front-line workers that held much of the detailed information around the individual and as such splitting the task into multiple sections, whilst creating an administratively efficient system, did not result in a good service outcome. The experience of the individual was one of a series of decisions being made apparently in isolation and without dialogue with the people they were to impact on. When Individual 6 spoke of not knowing how care agencies were selected or briefed before attending to support him there was an element of distress in being excluded from such a key decision for him.

Individual workers and managers spoke of trying to engage people in the decisions about their care or that of their family, without apparently being aware that, to the users of services, this was just one of a series of decisions that were being made about which they did not feel they had sufficient understanding as to be able to make a good decision. The individual relationships participants in cohort one had with workers was rarely negative, but, following a series of transactions with different local authority teams and workers, the participants found the experience confusing and distancing. This appears to be a systems issue rather than a skills one.

Conclusion

The interviews with staff demonstrated that there was a general awareness of the elements of social capital, even if the term itself was not in common use. However, the arrangements in place, particularly around recording it on databases, were not able to capture the range of individual networks or place any value from them to the individual. This led to front-line staff not fully

evaluating potential social capital and some evidence that assumptions about a lack of individual capital were not being tested. There was also a risk to the authorities that the limited recording systems were not able to record the differing views across an individual's networks resulting in poor decision making around the support offered.

The lack of recording also had an impact on the ability of the authorities to be able to identify and value social capital. As such, no evidence was found that the impact of social capital on the cost of care had been identified since the end of the pilot schemes reported by IBSEN in 2008.

Choice was bounded by the processes of the local authorities as they sought to manage a difficult financial environment restricting the availability of resources, but also as a result of the way that they sought to manage a competitive market through centralised planning. There was also evidence that there was limited appetite for innovation, with most support being given to top-down projects designed by professionals. Service users would see this as the authorities maintaining a strong control of the service delivery decisions and resources, despite linking it to personal budgets.

The limiting of choice and innovation have a significant impact on the ability of the individual to be able to take advantage of their social capital as they prevent people being able to maximise the support they have and then tailor public resources to meet the gaps. This also reduces the potential for the transformation of social care through personalisation.

Whilst managers spoke of policy including an awareness of social capital and personalised services, what was described as "vague" detail in national

guidance created scope for a tension between the implementation of a top-down policy agenda and the professional values of those expected to realise this, a classic environment for the street-level bureaucrat to appear. In continuing to adopt the behaviours of street-level bureaucrats, staff are demonstrating behaviours that frustrate the mobilisation of social capital, but also significantly limit the transformation to personalised services. This also harks back to the discussions noted earlier around the implementation of the NHS & CC Act ((Lewis & Glennerster, 1996) (Means, et al., 2008) (Glasby & Littlechild, 2016)) where the ambition to deliver a needs-led service supported by practitioners became frustrated by differential implementation, financial restrictions and the developing performance management culture.

The lack of a space in policy implementation for social capital has meant that mobilising it has remained a marginal aspect of service planning and delivery and its value to service delivery remained small. Where managers seek to develop projects that create community capacity, Putnam would describe the results in social capital terms as bridging ties. These, he said, were the weakest aspects, and in the first cohort interviews this was confirmed. The resources applied to developing community capacity need to be evaluated and used to cover areas of significant need, due to service failure, rather than as part of a universal offer as the resulting impact on social capital is likely to be weak.

In several of the interviews there were discussions around accessing social capital that tried to see informal support as part of the overall care provision to be commissioned. In doing so there were unexpected consequences as the

boundary between social and market norms of behaviour were not specifically taken into account.

In the literature there was a concern that the marketisation of services, along with self-directed support, would transfer the risk of service delivery to the vulnerable person. The interviews indicated that this was a real consideration and one of the reasons often given by participants in both cohorts as to why traditional services continued to be commissioned. This then reinforced the existing framing effect advanced by the behavioural economists.

In looking at the results of the first cohort of interviews alongside this second cohort, it is possible to see how the structure of the local authority services created a negative impact. In seeing the management of care as a series of individual tasks, similar to a manufacturing process, the two authorities had not identified that their role was to provide a dynamic public service that was based on a socially constructed relationship and the trust of the citizen. As such the aim of creating a person-centred service that fulfilled the expectations of personalised care was always going to be a difficult challenge, resulting in the observation that eight years after the start of the transformation agenda services were still quite '*traditional*'. (Service Manager 1).

CHAPTER 9 DISCUSSION AND CONCLUSIONS

Introduction

The study started with the intention of looking at social capital and how this was accessed in order to support the implementation of personalisation. As described previously in Chapter 3, the definition of social capital being used covered aspects of the approaches of both Putnam and Coleman. During the study Putnam's description, which described social capital as a property of relationships, was most useful in identifying whether individuals or groups had viable social capital. The work of Coleman (1988) became important to this study, given the elements of social capital he defined (see p.39), as they describe how social capital might then be seen to be having an impact.

Particular reference was therefore made to social networks, their value and how they were maintained. The study also looked at whether social capital contributed to the knowledge of the participant (its Information Potential), and their ability to relate to authority, as they planned the way that they would receive care and then whether the individual was able to draw on social capital in the delivery of support. In this way the study followed the proposal from Rostilla:

'a potential strategy is then not to focus on some general social capital indicator but on social resources relative [to] certain needs or goals' (Rostilla, 2011, p. 16)

One of the key questions to be answered from the methodology was whether there was a difference in the social capital of older adults or those with a learning disability. In terms of social capital there was no evidence that there

was a substantial difference between the populations of the first cohort, with the results being very similar across most fields. The results showed that, whilst all had very similar social networks, no population was fully mobilising its social capital. Therefore, the presence, or otherwise, of social capital does not explain the differential costs of services currently experienced.

As the interviews were structured to follow the responses of the participants a wealth of data was also gathered regarding not only the blocks that appeared in mobilising social capital, but also how the contacts with local authority staff (Authority Relations) created a delivery environment that significantly restricted participants' ability to explore and innovate.

A commentary emerged from the two cohorts of interviews regarding the policy implementation in adult social care that linked into the work of Lipsky (2010) on street-level bureaucracy. This framed the local authority approach to personalisation and the impact of this policy in terms of individual service delivery. The concerns of many participants in both cohorts included the need to ration services as a result of national spending reductions. The impact of austerity, in terms of innovation and developing service models, was an avoidance of any project where there was a risk of stimulating demand or increasing costs meaning that for most participants a traditional model of service delivery was adopted.

The impact of social capital

Social capital and social policy

The definition of social capital used in this study has followed the social capital theorists as they offer an established set of definitions. Whilst the Care Act guidance also tends towards a limited concept of social capital, based on a neo-capitalist model (Ayios, et al., 2014), this is not to say that it is the only definition that is considered by practitioners. The staff in the second cohort used a wider definition that included a range of community resources that would not be included in Coleman's description of organisations that were created or adapted to provide individual support and benefit from their input (appropriable or intentional organisations). As previously noted, this concept of social capital included aspects of community capital and was used in both host authorities.

From a research position this lack of a working definition of social capital has been problematic as there have to be judgements made as to the appropriate boundaries regarding what is to be considered. The use of Putnam's description of bridging and bonding ties, and the concept of reciprocity, were instrumental in clarifying this. In practice the publication of the Care Act guidance has been helpful in the way that it tends towards an approach based on the work of Putnam. With its, neo-capitalist, steer towards individuals being at the centre of supportive networks, that are reciprocal, the Care Act has sought to focus on social capital ties. This is not unexpected as some of the second phase of social capital theory was developed through work hosted by

the World Bank and included the UK Treasury (Field, 2008; Bartkus & Davis 2009).

The importance of social capital

The importance of social capital identified in this study is the contribution it is expected to make towards the planning and delivery of personalised services as they have come to be defined by the Care Act. If the individual is to be able to take control of the support that they need, they should have a good understanding of what would work for them, what support can be realised, and how it can be facilitated. The use of social capital has been shown to support wellbeing and health gain for the individual:

‘People who are able to draw on others for support are healthier than those who cannot.’ (Field, 2008, p. 49)

Indeed, there is an argument that there is a link between high levels of social capital around an individual and the quality and efficacy of the healthcare they experience.

‘In the ongoing quest to improve our understanding of the conditions that make for improved public health and wellbeing, scholars, practitioners, and policymakers have recently returned in earnest to a theme with a long and distinguished history in the social sciences—namely, following Durkheim, the importance of social circumstances in shaping the quality of life one enjoys.’ (Szreter & Woolcock, 2004, p. 650)

Many of the arguments put forward by Szreter & Woolcock, whilst specifically related to public health, could be transferred to social care. Those that had the strongest control of their support, in cohort one, utilising their networks and access to community knowledge, also demonstrated the greatest overall satisfaction with what they received.

'The oldest school of thought, the 'social support' view of social relationships, would tend to imply that, at least from an individual's point of view, any kind of positive social support is good for your health.' (Szreter & Woolcock, 2004, p. 661)

The findings reported from the interviews, particularly the first cohort, were consistent with the observation that social networks increase the individual's quality of life. This in itself would support the citizen led agenda for personalisation, that the gains in terms of quality of life in itself is sufficient to adopt this policy. Through access to knowledge and a range of support, social capital has the potential to enable individuals to adapt or create services that best meets their needs at the point or receiving support. By facilitating this at a personal level, the gain strategically is that resources are more like to be effectively targeted at actual needs, reducing the risk of overprovision when social workers commission support based on a 'highest likely need' scenario. By accessing the minimum level of support individuals experience less intrusive care, often an indicator of a better quality of life.

With reductions in national expenditure on social care there is the question as to whether social capital could contribute in financial terms to support the reduction in resources that has occurred, which requires more than an increased quality of life. The evidence was that this could not be relied upon and that the observations from the pilot study, of better resource use, could not be attributed to access to social capital.

The Care Act guidance started off with a discussion of prevention which included the expectation that an individual's social network would be assessed for the support it offers, before consideration was given to the use of state resources. This is an example of a policy that is looking to informal

support as a way of minimising the demand on state resources, or maximising the reach if the state has to fund services.

The presence of social capital

The evidence from the interviews is that individuals are able to define their networks, but that these are not effectively being mobilised for support. Whilst accessing social capital is not necessarily a conscious decision, at a time of transition such as accessing external support it may be necessary to instigate this. Front-line workers are aware of the importance of social networks, but they rarely have the time to explore or promote the role of these relationships and do not then have the tools to record what these networks can offer. As the facilitators of most support arrangements, front-line workers and those responsible for commissioning services are not able to maximise the potential contribution of an individual's social capital. As the assessment, planning and delivery of care is passed as discrete tasks between teams or organisations this lack of continuity of knowledge about the individual's social capital leads to the resulting service appearing to be detached and not person-centred.

The importance of the procedures in place to guide staff was recognised, but the link to their implementation through 'screen-level bureaucracies' was not understood. The poor recording of social capital in ICT systems has resulted in care plans that do not seek to exploit what is available or recognise the role social capital can play when commissioned services fail. Whilst the literature described the way that good system design can enable practice to be developed, the experiences given were that this was not being achieved for either practitioners or citizens. The central drive to deliver public services

electronically has a limited application where the purpose of the interaction is to assess risk and vulnerability as well as promoting individual strengths. Whilst commentators like Slasberg and Beresford (2017) advocate strengths based approaches and engagement at an individual level as being part of the direction of travel for personalisation, the fundamental change in approach from the public sector will not occur whilst they remain constrained by the systems they use.

The second cohort of participants concentrated on the impact of social capital to deliver aspects of the support package rather than contributing knowledge to planning support, an aspect that might result in a challenge to the position of the worker or the council. What was being described by local authority staff was a narrow perspective of social capital that was bounded by the practice, tools, and procedures of the organisations. As such the presence of social capital being assessed by practitioners could easily miss key networks that may offer alternative approaches to support, offering better support and an improved quality of life for the individual. This has a particular risk in that it is reinforcing a stereotypical understanding of what constitutes significant personal relationships, that would not recognise support from a wider community or the increasing complexity of relationships people have developed in a post-modern society.

The use of innovation was explored as a study of the mobilisation of social capital. Without access to good information from their social network, accessible community information resources, or good support from front-line workers, innovation is unlikely to occur, which is in line with what this study

was finding. In this way the control of the street-level bureaucrat is maintained despite the ambition of a transformational policy such as personalisation.

Qualitative gains from social capital

In addition to the qualitative gains that networks add to the delivery of support, social capital theorists would add the gains anticipated as a result of better information to support personal decision-making and an understanding as to how to mobilise authority to make it happen. In the study there was significant evidence that this was not happening as the approach to policy implementation, through street-level bureaucracy, meant that front-line workers sought to retain their control over resource allocation and deployment. This was complicated by the impact of austerity making the financial impact of changes more significant. The indication from the second cohort interviews and the reports of senior managers (Jackson, 2015) was that austerity had become the pre-dominant factor for local authorities, meaning that they would support front-line staff in controlling the use of public resources.

Commentators had previously discussed the way that financial restraints had frustrated the ambitions of Community Care and care management to create a user-led service that empowered individuals, creating instead a procedural bureaucracy that controlled delivery. The results of this study are an indication that there is a risk that the same thing is happening again, that the liberating intentions of personalisation are being subsumed by the need to exercise stringent financial controls to demonstrate that austerity is being delivered upon.

The value of informal support

What the study did indicate was that the support received was, in the main, the tasks that would not be funded by a local authority (see table 6.4, p126). The results of the interviews were consistent with the research undertaken by the Office for National Statistics (Foster & Fender, 2013). This presents a challenge to the methodologies used to evaluate the contribution of informal care to the economy in that there is no separation in the published data between those that are, or would be eligible, for state funded support and those that are not. The alternative methods are to value either the support we offer each other as a community (without a link to the resources for health and social care) or an estimation of the savings informal carers offer the public sector (a smaller figure, but one that has not been quantified using current eligibility criteria). In their 2015 report, Carers UK took the first method, using reported levels of support offered by all carers in the Census, to value informal care at £132b per annum (Buckner & Yeandle, 2015). An estimate of the second method, based on the results of this study, limiting support to an average of 21 hours/week would indicate a savings to the public sector closer to £40b. Regardless of the approach, when the expenditure on adult social care for 2014-15 was £17b (Health and Social Care Information Centre, 2015), the value of informal support remains a significant contribution to the overall support provided. A small reduction in the willingness of the community to offer informal support would have a disproportionate impact on public sector resources.

Coleman's view of social capital recognises the role of social obligations and expectations in motivating members of the community. Contrary to Putnam's

concerns about the decline in social capital (Putnam, 2000) the Carers UK report notes that the number of informal carers has increased (by 17.7% in England between 2001-15) leading to a 95.5% increase in the value of support over the same period (Buckner & Yeandle, 2015). The indication is that as a community we are providing more support than in the past and at greater levels to each individual. As informal support is drawn from social networks maintained by the individual, the inference is that this is an increase in the role of bonding ties and some bridging ties in social capital.

It is not possible to say from this study that the motivation to provide this support is as a result of gaps appearing in the support from local authorities, but the awareness of the participants in the first cohort regarding resource constraints and the rationing behaviours of front-line workers would indicate that they expect to be drawing on social capital to meet needs outside of those covered by the eligibility criteria.

Given the value of informal care, it is surprising that local authorities do not make strenuous efforts to understand the impact of individual social networks and ensure that they are appropriately mobilising them. The caution for government is that in trying to stimulate social capital it is also possible to undermine it (Field, 2008, p. 154). As Bourdieu was indicating, social capital between members of homogenous groups is unlikely to result in wider opportunities for vulnerable groups, what is needed is a wider mix of skills and knowledge being brought together. However, government actions tend to be focussed on groups of individuals with similar needs, such as the Partnerships for Older People Programme, reducing the potential for social capital based change.

The other tension around carers is the concept that each person has a single carer. Often this is appropriate, but the interviews indicated that this was not the only option. Council staff indicated that their database system does not recognise multiple informal carers as an option against which activity and allocations can be recorded. The interviews raised the potential for local networks to be developed to support individuals with multiple carers (Team Manager 2 and Social Worker 2) where more than one carer would be eligible for an assessment. Not only is this a risk in terms of the authority being liable for failing to support each informal carer, but the provision of support to one will have an impact on the behaviour of the others. This complex set of interactions would require active management by an independent broker, something neither authority could offer.

In looking at the motivation individuals have it is necessary to understand the social norms that have a contribution to Coleman's (1988) concept of social capital and the market norms that do not.

Social and market norms

An inherent understanding of social norms came over clearly with the first cohort who were able to define when they accessed their social capital on the basis that it was a social norm, they understood the different bases on which they received support and both valued them and understood their reliability. As such this fitted in with Coleman's (1988) description of utilising social capital, in particular the elements of 'obligations and expectations' and 'norms and sanctions'.

Equally they understood the relationship as a market exchange and the importance of appropriately valuing exchanges with paid carers. Viewing the relationship as a market norm defines the paid carer as being outside the individual's social capital, although some undertook more tasks than were defined in their work schedule and provided an element of companionship and even friendship. The strong links some participants developed with individual paid carers appeared to challenge this market exchange model, the weakness of such a binary model. Whilst the paid carers had particular influence over service delivery, the more socially independent participants recognised the tension between social and market exchanges and managed it accordingly.

In contrast the local authority staff struggled with the appropriate boundaries between social and market exchanges. In order to create support that was consistent and reliable, a bureaucratic requirement, the council staff tended to look towards offering financial incentives to informal carers, such as grants for activities, in their projects. However, this then presented the risk that, by not recognising the constraints within Coleman's obligations and expectations of social capital, they were blurring the motivation of informal carers between social and market norms. With the local authority offering carers paid respite care in the home, or carers grants, alongside regular payments available from the Department of Work and Pensions they are placing an alternative measure on the value of the carers activity, although it is still less than the market rate for the support provided.

Both situations outline the difficulty in defining social and market norms of behaviour in the care environment and that front-line workers with only superficial contact with the individuals being supported are unlikely to be able

to manage the subtleties involved in re-forming these changed relationships. As this is in the skill set that Lymbery (1998) describes as being that of a social worker, rather than necessarily the process defined care manager, the reflections of the senior managers on the skills available, as noted in the second cohort, become more pertinent. In practice it is probably left to the person being supported, or their immediate network, to manage the dynamics of these relationships and the risks that this entails.

The concept of a consumer market for care is no longer the uncertain new venture Lymbery (1998) was considering, with few services directly provided by local authorities to a restricted set of people. What is missing is the active participation in it by people needing support creating a demand for innovation. Instead what we have is a group of choice architects (including front-line workers, managers and commissioners) that shape markets to meet national targets not personalised care.

Social capital – the ethical conclusions

In the Introduction, Bourdieu was noted as saying that social capital was a neutral property whose value was dependent on how and what it was formed of. The interviews indicated that, for the participants, their social capital was of limited value to the planning of support as there was neither the access to, nor information within, networks to make a difference. Whilst this in itself should not be an issue, the assumptions in the policy implementation that it was there have resulted in gaps in provision for individuals, not least that individuals were operating without a 'safety-net' in their care provision. With the limited engagement between front-line practitioners and individuals, this is a risk that

is now typically held by the individual. As such this is moving social care into what Ayios et al (2014) defined as a Neo-Tocquevillian model with its restrictions on the ability of the individual to exert their wishes, a direct challenge to the ethos of personalisation. People need to be supported to innovate and take risks, an appropriate role for the state rather than untested social networks, if they are to be able to re-frame their concept of care.

Social capital has the potential to deliver improvements in the delivery of personalised care, but policy-makers and practitioners need to be realistic as to the space it occupies in the planning and delivery of care and support as the study indicated that so far it had not been mobilised as a positive contribution.

The impact of austerity

Austerity and personalisation

The interviews presented a concerning picture of the transformation of adult social care through personalisation. Personalisation was developed as a response to the desire for users to have a voice in the way that they were supported. The intention was that individuals and their networks would be supported to take control of their lives, and for the support they need to be delivered in a way that enhances their quality of life. In implementing personalisation at a time of extended national austerity it has not been possible to realise the ambitions of those that need support. Indeed West cautioned that an ambitious policy with relatively untested financial assumptions could not succeed at a time of significant spending cuts (West,

2012). This study supports that view and has sought to understand some of the ways that this has played out with those planning and using services.

With the national planned expenditure for 2016-2020 including drastic short term reductions, followed by a return to a position slightly below the starting point (The Health Foundation, 2015), the response of local authority managers is going to be to seek further reductions in expenditure. West (2012) describes in detail the way that one authority has already used the language of personalisation to distract attention from a significant reduction in services. It is likely that the simultaneous promotion of personalisation and spending reductions are going to result in a public perception that they are part of the same policy, resulting in public antipathy to personalisation. The implementation of the Care Act, the legal codification of personalisation, has not sought to separate these two policies which leaves a significant risk that, by 2020, an alternative approach to service delivery will be required.

Social Capital in a period of Austerity

The impact of austerity appears to have had three main impacts on the delivery of social care. As outlined above it has created an environment which is financially risk averse and has resulted in front-line staff using bureaucratic responses to significantly limit the vision of personalisation. In the worst examples personalisation had become the vehicle to justify significant reductions in the availability of social care without ensuring that it was not placing people at risk (West, 2012).

The reductions in real spend on social care to 2015 of 26% (Jackson, 2015) has seen a reduction in the social work workforce. This reduction in capacity,

along with the concerns around the skills of the workforce identified in the interviews, raises particular concerns about the ability of front-line staff to be able to support individuals in accessing their social capital. The study brought together concerns about not only the ability of front-line staff to act as facilitators to support innovation and flexibility, but also the systems and organisational governance in which they worked. Whilst local government sought to minimise the cost of its infrastructure it has also reduced its capacity to innovate itself out of the financial strictures created by the austerity programme. One aspect of this has been to reduce the capacity to support individuals in accessing their social capital more effectively and so reduce the demand on services.

Whilst the study was considering the ability of individuals and workers to access social capital, it is recognised that there is an assumption that the availability of social capital is constant. The indication from studies such as that of the NEF (Slay & Penney, 2013) is that it may not be that drawing on social capital is that easy:

‘Cuts to public services and tax credits are placing an impossible burden on people who have to step in and look after family members while doing paid work. As demand for care rises, a growing strain is placed on unpaid human resources and relationships.’ (Slay & Penney, 2013, p. 5)

Previous studies have demonstrated that the majority of unpaid care is undertaken by people with the least personal resources, often women. The assumption that when there is a need social capital can come forward to meet any gaps, has not been tested or quantified. Putnam proposed that social capital was declining and although Hall (1999) argued this was not the case in

the UK, there have been no recent studies to confirm that social capital has not reduced since. What we have not tested is the individual impact of the loss of services, through austerity, on people who are already subject to multiple vulnerabilities due to infirmity or impairment. The implication of the increase in the number of informal carers (see p.192) is that there is more demand on social networks, without any evaluation as to whether this increase in informal support is adequate and appropriate.

Street-level bureaucracies and austerity

In times of austerity measures, it is particularly relevant to study the impact of these measures on street-level bureaucracies and their staff's capacity to achieve what is expected of them. (Hupe & Buffat, 2014)

Whilst the historical actions of social workers have been described as fitting the model of the street-level bureaucrat this has been delivered with a nod towards Tummers and Bekkers (2014) concept of delivering a meaningful service to their clients that encourages staff to implement new or developed policies. What was seen in this study was an increasing distance between the practitioner implementing the policy of personalisation against an awareness that they were working in an increasingly restrained performance management environment and resources that were not sufficient. Using Hupe and Buffat's (2014) public service gap model this would be described as meeting increasing demand for services with a similar or possibly reduced level of resource.

The experience of this study indicates support for the view that austerity has not only reduced resources available for the provision of care, it has also had

a negative impact on the ability or willingness of front-line practitioners to mitigate the negative aspects of service delivery. Front-line workers confronted with increased performance management and less resources to deliver services inevitably feel increasingly devalued.

the loss of professional agency nonetheless means that the ability of social workers to deliver the service they desire professionally, in the interests of their clients, has been compromised by the bureaucratic arrangements to which they are obliged to conform. (Wastell, et al., 2010)

In the interviews with cohort two there was a good range of evidence to support Bovens and Zouridis' (2002) view of a system-level bureaucracy with its limitations on practice and decision-making. This evidence of curtailment was much stronger than the enablement theory Buffat (2015) put forward, despite the authors conclusions that it would not be suited to a service that interacted at the front-line with individuals.

Street-level bureaucracies are sensitive to the political environment in which they operate, being the boundary between the policy maker and the citizen. Having described the development of the role of the local authority social worker as the allocators of resources, since the 1980s there appears to have been little fundamental change in the underlying basis for their work. The social worker in England continues to be recognised as a street-level bureaucrat, although the pressures of austerity have reduced the scope for practitioners and their managers to use this model as an enabling tool. The Care Act has presented an opportunity to refocus social work, but this requires significant change at a time when the evidence is that managers and

practitioners are not able to encourage any form of risk that may have a financial implication.

The impact of the Care Act

As a result of the interviews there are a number of issues that came out showing a direct impact on the implementation of the Care Act.

Information

The lack of information was a significant issue for those planning their own services; the lack of good information partly resulted in users of services opting for models and providers suggested by front-line workers. Social workers reported that they were often asked to arrange care as, they believed, that people did not want to take on the responsibility (Social Worker 1), yet the first cohort indicated that the participants did not feel sufficiently well informed and supported in order to make good decisions. The Care Act places a specific duty on local authorities to ensure that this is in place on the basis that:

‘Information and advice is fundamental to enabling people, carers and families to take control of, and make well-informed choices about, their care and support and how they fund it.’ (Department of Health, 2016, Section 3.1)

Given the failure of information provision prior to the implementation of the Care Act it would appear that getting this resolved would be essential to achieving the aim of creating informed consumers. However, both authorities were looking at creating new online arrangements as their key response. Each was behind target with the ownership of the projects split between directorates. It was not possible to evaluate the impact of the revised

arrangements for providing information, only to note that this is a significant challenge to both authorities which does not appear to be resolving quickly.

Decision making

One of the biggest cultural shifts in the Act was the aim that decision-making should be the remit of the person needing support, unless there were exceptional arrangements based on a person's lack of capacity.

'The person must be genuinely involved and influential throughout the planning process, and should be given every opportunity to take joint ownership of the development of the plan with the local authority if they wish, and the local authority agrees. There should be a default assumption that the person, with support if necessary, will play a strong pro-active role in planning if they choose to. Indeed, it should be made clear that the plan 'belongs' to the person it is intended for, with the local authority role being to ensure the production and sign-off of the plan to ensure that it is appropriate to meet the identified needs.' (Department of Health, 2016, Section 10.2)

Both sets of interviews indicated that much of the decision making after implementation continued to be led by front-line workers as choice architects. There was an acknowledgement amongst front-line staff that they should be person-centred and that the person should be part of the decision, yet the behaviours and situations described by both cohorts indicated that the final decision remained with the professional, a position that has remained in place since the introduction of the NHS&CC Act in 1993 (see Chapter 2). In describing the behaviour of the street-level bureaucrat Lipsky (2010) proposed that it was an inevitable response to a set of triggers specific to public service organisation. As such, changing the procedures front-line staff are expected to follow is unlikely to make a significant change in who makes

decisions, when the same staff still control the resource allocation on behalf of the state.

The research indicates that it is probably going to take a fundamental change in the governance of resource allocation if front-line staff are to become the facilitators and advisors needed to support individuals adopt a role as informed consumers. Given the risks to local authorities of losing resource allocation and care planning as the primary tool for managing increasingly restricted finances, it is not possible to see how this could be implemented without an agreement around risk sharing with central government. Providing un-negotiated grants, to support implementations with ambivalent guidance, will not create the transformation required. Transformation will only occur when the front-line workers and managers believe that it is safe for them to participate, something that was not delivered in either the NHS&CC Act, personalisation and now Care Act implementations.

Flexibility in support

The interviews showed that people were often directed towards a specific service option using a limited range of providers. The guidance states:

‘The concept of ‘meeting needs’ is intended to be broader than a duty to provide or arrange a particular service. Because a person’s needs are specific to them, there are many ways in which their needs can be met. The intention behind the legislation is to encourage this diversity, rather than point to a service or solution that may be neither what is best nor what the person wants.’ (Department of Health, 2016, Section 10.10)

In each set of interviews evidence was given that the local authority procedures, and the expectations of staff, led to the allocation of particular

services. For the service users this was accepted with resignation (Individual 6) or confrontation (Individual 3) with the framing of social expectations meaning that in practice it was rarely challenged. For the staff it was seen as meeting the organisation's need to deliver good governance and financial management of resources. In most of the interviews there was little evidence of front-line workers accepting the opportunity to consider flexible approaches to meeting individual needs; where innovation did occur it tended to be led by service users or their families.

The current resource allocation arrangements have not met the expectations of the original aims of personalisation, nor the Care Act, in that the emphasis on predictable service costs has become more important than the potential risks and savings associated with giving people control of their support. A key outcome of transformation was that the allocation of resources was to be transparent and readily set against needs. The participants in cohort one clearly did not understand the basis for their allocation, and the professional staff in cohort two saw it as an issue for others.

Resources

In the interviews with council staff the conclusion was that, despite pre-implementation training and nine months of practice, front-line staff were still working in a traditional manner, something their managers were aware of.

The concern about the availability of resources as a result of the new National Eligibility Criteria was reported by 48% of local authorities in the months leading to implementation (National Audit Office, 2015). Whilst there was an acknowledgement that there was going to be an increase in the numbers of

assessments of vulnerable adults, there was also an expectation that there would be a significant increase in the number of carers' assessments. Despite this there was only a limited provision made for additional care costs. The NAO raised concerns about the sufficiency of this provision given that the methodology relating to its allocation included a number of untested variables. This led it to the conclusion that as many as 64% of local authorities could be underfunded for the new responsibilities:

'In a challenging financial environment, with pressures on all services, local authorities may not have sufficient resources to respond if demand exceeds expectation.' (National Audit Office, 2015, p. 43)

The result has been that, as hypothesised by the NAO, local authorities have responded by encouraging staff to manage the demand for resources by retaining restrictive front-line practices. As such the aim of the Act, to reclaim social work practices, is being subordinated to the need to retain control over resources, with authorities continuing to tacitly support staff acting as street-level bureaucrats.

Looking back to the policy implementation literature this situation could have been anticipated if a stewardship approach (Hallsworth & Rutter, 2011) had been adopted rather than a distant top-down methodology. This lack of engagement with implementation also explains why, part way through the plan, the financial reforms based on Dilnot's recommendations were deferred for at least five years (Triggle, 2015).

Answering the research question

The initial question was whether social capital had an impact on the personalisation of social care, if so was it sufficiently valued and trusted that it could contribute to support. This study has shown that, whilst individuals have social networks, the way that services are being planned with the involvement of local authorities meant that the social capital they might have is not being effectively accessed to contribute towards the care that would be commissioned for them. They do have informal care, but this has not been encouraged or maximised by the actions of front-line workers. The assessment approach in the Care Act seeks to address this, but it is too early to say if it will make a difference once it is embedded in practice.

As there has been no evidence of flexibility or innovation it cannot be asserted that social capital has made a contribution to the reduction in the cost of social care to local authorities. Given that the interviews demonstrated that the current approach to assessments and their recording provide no space for the consideration of social capital it is not unexpected that once the commissioning of care is professionalised, social capital is not exploited across an individual's full social network. Social capital continues to support people with tasks not considered eligible for state funded support and outside the scope of authorities.

The lack of awareness of social capital within commissioning systems also means that there is no aggregate record at local or national level to identify the impact of informal care amongst those receiving funded support, which would at least identify the value of direct support from social capital. Indirect

support, such as information provision and relating to authority, is unlikely to ever be valued in economic terms. The limitations around mobilising social capital, its space in commissioning and the difficulties in valuing it mean that it is not possible to ascribe a monetary value to social capital as part of local or national budget setting.

There was no evidence that older people experienced more social capital or were able to draw on their social networks differently compared to people with a learning disability. The conclusion from this is that social capital could not be considered a factor in the differential cost of services to these two populations.

Behind this there are a number of issues around individual abilities, decision making, and local authority processes that result in a fragmented public service that participants did not relate to as a form of support. Participants in both cohorts ended up describing the process of managing care as an adversarial negotiation over money and budgets with the power and control firmly in the hands of the local authority. This was not the vision that would be expected if social capital was having a real impact. The availability of information, and skills in managing authority drawn from social networks should have reduced the power imbalance in the relationship, but this did not happen for most participants.

The study showed that policy implementation can still be seen through the lens of Lipsky's street-level bureaucracy and that this goes beyond the formal decision point of the eligibility criteria to include the planning and delivery of care and support. This is tacitly supported by managers seeking to manage,

in a time of significant resource reductions, either through decision making processes or the structure of organisations managing aspects of the workflow.

Initially personalisation was portrayed as being able to maximise resource use through encouraging and facilitating innovation using social capital. Six years after the guidance was launched there were few examples of innovation amongst the participants in both groups, certainly not at a level that would contribute to reductions in the community-wide demand for resources. Personalisation as a concept continued to retain an engagement amongst local authority staff, but had failed to deliver an increase in the quality of life for service users or be a meaningful experience for most participants.

Where there was a quantifiable contribution from a social network towards a participant's care there was no evidence that it had been increased as a result of personalisation, and where local procedures were discussed they appeared to reduce the ability of participants to achieve a reduction in the cost of services.

Limitations of the study

The study was undertaken with host sites that were willing to host the study, it did not make any attempt to balance participation across the different cultural and ethnic groups to be found in England. Hall (1999) noted that there was a difference in social capital between Britain and the US, so it is likely that there will be difference within specific groups in the UK. The sample was balanced in terms of gender, but with the small numbers in a qualitative study this may result in unidentified bias. The study focussed on the experience of those

currently accessing state support, half the relevant population; we have no data on the way the other half use their social capital.

The number of participants was a concern throughout the study. The initial approach to potential participants required that they respond to an invitation distributed by the local authority, which had a low return rate. Using contacts in local organisations was more effective, but introduced the risk that third parties might be able to track contributions. Had the results of the interviews with the first cohort not been so consistent it would not have been possible to continue with the study. Using local authority staff was easier to arrange and did give a range of views on which to reflect on the experience of individuals. This sample could not have been significantly increased in numbers as most senior managers in each authority were interviewed. It was this second group that made it possible to place comments in perspective. However, the results of any case study based on a small sample need to be verified through further study or experience.

In reviewing the impact of social networks no account was taken as to the strength of individual relationships. The initial hypothesis was that there would be differential levels of social capital between older adults and those with a learning disability. This should have been shown by a difference in the number and range of networks experienced by the individual. As such it did not appear to be necessary to test the strength of each network. Having since established that there are similar social networks in place for both groups, there may be a value in looking at the strength of these different networks using a tool such as social network analysis. This could be more accurate than the approximate approach of identifying Putnam's bonding or bridging

ties and might better assess the impact of community capacity building on individual social capital.

The study was undertaken during a period of significant policy development, which meant that there was not a direct comparison between the environments for cohort one and cohort two. As such the local authority staff had an opportunity to reflect on the differences that the Care Act made, which was not possible with the other participants. Given the rate of implementation, it is likely that it would be several years before sufficient numbers of participants would be available who had experienced a review and care and support plan to be able to hold an informed discussion on its impact.

Further research

As with many qualitative studies the approach is one of theory building that in itself contributes to the understanding of a phenomenon, but does not usually propose a radical interpretation. In using Coleman and Putnam to define aspects of social capital it has been possible to undertake an assessment of the impact of social capital in one aspect of social care. With the introduction of personal health budgets, which operate in a much more controlled environment, there is a value in looking at the aims of the personalisation of health care policy and how the observations noted regarding social capital and the responses of front-line workers may be relevant.

Coleman recognised the importance of social capital as a way of sharing information and knowledge across a community. This was before the internet and its ability to make information available to the whole community. It has the potential to be a significant factor for people with an impairment as it is

independent of personal mobility. Social media may also be a new avenue for peer-support and advice on managing authority relations. Consideration of the impact of social media on social capital is in its early stages, none of the writing has considered its role in supporting people with disabilities and their carers.

APPENDICES

Appendix 1 Letter to Participants



UNIVERSITY OF
BIRMINGHAM

College of Social Sciences

Date as appropriate

Dear Sir/Madam

Please accept my apologies for the impersonal greeting. This letter has been sent to you by XXXX XXXX Council, on behalf of the University of Birmingham and myself; they have not given your details to me.

I am a student completing a Doctorate at the University of Birmingham and am currently conducting a research study looking into the experience people have arranging their own personal care. I would like to talk to you about the experience that you had with your arrangements. Included with this letter is an information sheet that gives you more detail about what I would like to talk about and why. There are also versions available for family members and in Easy Read formats. You can get copies of all the documents on my website www.ia-c.co.uk/study.


The results of the study so far have been very interesting and I expect that they will be used to inform the approach to personal budgets in the future.

Being involved in the study is voluntary and whether or not you join in will have no impact on your support arrangements with the Council. Being involved should take no more than two hours and where we meet is your choice. Previously I have met people in their own homes and the interview has been about 90 minutes.

Once you have read the information and you agree to take part please contact me (the details are at the bottom of this letter) and we can arrange to meet.

I do hope to meet you shortly.

Yours faithfully


Nick Willmore

Appendix 2 Cohort One Participant Information

Contents:

- a. Participant Information Schedule
- b. Participant Information Schedule (Easy Read)
- c. Participant Consent Form
- d. Participant Consent Form (Easy Read)
- e. Interview Schedule



Participant Information

Project: The Role of Social Capital in the Personalisation of Care

Investigator: Nick Willmore

Sponsor: University of Birmingham

Course: Doctorate in Business Administration

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. At no time will participation in the study, or choosing not to do so, have any impact on the care and support you might be receiving from the local authority.

What is the study about?

The study is looking at two things with a common link. Firstly it is trying to establish if the support required by people is influenced by their existing networks and if so is it different for different groups of people? Secondly does the support provided to people with a learning disability have to be more expensive because they receive less natural support and so carers have to be more pro-active when supporting them?

In 2009 the Government announced that there was to be a transformation of social care in which individuals and their families would be able to take control of their care resources and arrange their own support. The early pilots showed that this was a way for the cost of state funded care to be reduced without cutting care. Indeed for many it resulted in an improved quality of life. Since then the resulting arrangements have not been as promising, so the question is why not. The study is taking one aspect behind the way that people organise their support (their normal relationships, friendships and community links) and investigating what the real impact this has on individuals.

Risks and benefits

The study does not involve any changes in your care arrangements and is not linked to the assessment that the local authority undertakes. Therefore there are few risks to being involved in the study. The main risk is that we will be talking about what happened to you when your care was arranged and sometimes this can be upsetting. If you think there will be strong feeling about this for you, you might want to think about whether you wish to participate.

The benefits are similar to many of these studies in that participants report that it is helpful talking about how things that become important to them happen as they can gain an insight into how to better organise things in the future. An interview that is set out to discuss the different aspects of a decision or event can also help the participant better accept what has happened to them. Each person gets something different from this sort of experience, but it is unusual for someone to get nothing back.

How will the study work?

The study will involve interviews with 40 people who receive funding from local authorities. Half will have a learning disability, the other half will be older adults. They will be selected at random by the host local authorities and their agreement sought to participate in the study. Only once this agreement is obtained can the local authority share details such as addresses with the researcher.

Once you have agreed to be involved as a participant the researcher will make contact and arrange the interview. Each interview will take about two hours to complete. This can be split over two sessions if you prefer, and we will certainly want to take breaks during the interview if you are willing to do it in one session.

The interview will take place in a venue of your choice whether that is your home, a community venue or wherever you feel comfortable. At the start of the interview the researcher will ensure that you understand what is involved and together they sign the consent form. The interview will loosely follow a prepared list of subjects, but will be guided by you. To ensure that the interview is accurately captured it is proposed that it is recorded on tape and then transcribed into writing. As a participant you will be offered a copy of the written record or the audio recording; the choice is yours. You will be asked to check that it is accurate as far as you can recollect.

You may prefer to be interviewed on your own, or with one or more family members or friends. As the study is looking at the way that these people contribute to your life they are more than welcome to join us in the interview.

Occasionally interviews bring up difficult experiences and emotions. Sometimes we can work through this together, sometimes we might have to ask for someone else to offer longer term support. We can sort this out together if it

seems appropriate. However we rarely come across issues that need to be addressed as a safeguarding concern (such as neglect or inappropriate financial dealings). If the researcher were to hear of significant concerns for your welfare there would be a requirement that the appropriate local authority team is notified.

What happens next?

After the interview the researcher will be bringing together all the interview results and looking for common themes. This is expected to be finished at the end of October and will then be set out in a report that forms part of the final thesis. This draft report will be sent to you to comment on. It is possible that in the report there will be quotes taken from individual interviews to be used in the final thesis; this will be highlighted to the individual(s) concerned..

What will the researcher be told by the host site?

The only information we are asking from the local authorities in the study is for contact details for individuals, whether they have a personal budget or direct payment as part of their care provision and whether there are active family or friends (but not their contact details). As to the reason for support this only needs to be whether you are an older adult or have a learning disability. The final information will be whether you have any specific communication needs. We do not want details about your care, or the history of care arrangements. You are the person that tells us about your needs and why care has been allocated to you.

What consent am I asked for?

In giving your consent to be interviewed you will also be giving your agreement that what you say can be used anonymously in the final report and thesis. This means that if, after the interview has taken place, you lose mental capacity to give consent, what you said would still be used.

What personal information is held?

The final thesis will be available to the public so, in the reports it is based on, no information that could identify you will be included.

The records of interviews and other documents used in the study will refer to individuals by their initials. In order to manage the study there will be a master key, which will include all the contact details relating to you and the initials used to identify your interview elsewhere in the study. This makes it very difficult for someone other than the researcher to link individuals and the comments they might make. The master key will be kept in a secure electronic file separately from the interview records.

The study is being undertaken by a part-time student who also runs a social work business, IAC. The study records will be held on a secure server owned by

IAC. Only the researcher will have access to the records and the master key referred to above. This is a practical response to living in Sussex with the university being in Birmingham.

A year after the study is completed the master key will be destroyed so no-one will be able to identify the participants. The records of interviews will be kept for ten years in case anyone wishes to review the conclusions of the study.

Contact details

For further information on the study, what is involved and the arrangements relating to participants the researcher can be contacted as below.

Telephone		email	
Address			

To verify the authenticity of the researcher or the study please contact the Health Services Management Centre at the University of Birmingham.

Telephone		email	
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Thank you for considering participating in this study and I hope to meet you in the near future to take it forward.

Nick Willmore

19 September 2012



Research Information Sheet



My name is Nick Willmore. I want to know who organised your care and who helped you do it.



I want to meet you to ask you some questions.



You do not have to meet me



If you meet me I will record what you say.



I will put what you tell me in a report.



I will not use your name in my report.



I will tell you what I have written.



You can choose when to meet me.



You can bring a friend to the meeting.



You can choose when to stop the meeting.



CONSENT FORM

Project: The Role Of Social Capital in the Personalisation of Care
Investigator: Nick Willmore
Sponsor: University of Birmingham
Course: Doctorate in Business Administration

Please initial box

- 1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.
3. I agree to take part in the above study.
4. I understand that if, after the interview has taken place, I lose my mental capacity to give consent, what I said at the interview would still be used in the study.

Please tick box

- 5. I agree to the interview / consultation being audio recorded
6. I agree to the use of anonymised quotes from my interview in publications, reports and the final thesis relating to this study.
7. I agree that my data gathered in this study may be stored (after it has been anonymised) by IAC Ltd for the purposes of the research and any future questions relating to it.

Name of Participant Date Signature
Name of Researcher Date Signature





UNIVERSITY OF BIRMINGHAM

Research Consent Form



Nick can meet me



yes



no



Nick can record what I say



yes



no



I can choose when we meet



yes



no



I will bring a friend to the meeting



yes



no



Nick can use what I say in his report.



yes



no

My name:

My signature:

Today's date:

Interview schedule for participants

Project: The Role of Social Capital in the Personalisation of Care
Investigator: Nick Willmore

The interview will be informal and take the form of a discussion, which will be guided by the interviewer. At the beginning you will be asked to tell the interviewer about the way that your care was arranged using your personal budget. If the interviewer needs to better understand what you are saying or a point is of particular importance you might be asked some additional questions.

The list below covers the areas of interest to the project. You may not be asked anything specifically about a topic as it is possible that it has already been covered earlier in the interview.

Social capital is the benefit we gain from contributing to society at a personal level through friendships, relationships and membership of social organisations. The current assumption is that this is something that will support us when we need help due to age or disability. This study is trying to check that this assumption is valid and if so how robust it might be.

Topics:

Setting up care arrangements – How was this achieved and how does the cost of the package compare with a traditional care managed approach? What impact did others have in setting up the package, directly or indirectly?

Personal history – how have you linked to communities in the past (clubs, societies, informal social groups, friends etc) and how long have the current links been in place?

Networks and community links – What has been your involvement in networks and communities? What are you involved in now? What have others from these groups done for you in the past, and now?

Trust and commitment – How much do you rely on networks for support? How much do you trust the stability of them?

Maintaining social capital – What is required to maintain the support from your networks and relationships? Is this sustainable for you?

Value of social capital to the individual – What arrangements would have to be made to replace resources available through your social capital? How would you assess the contribution that social capital has made? Can it be expressed in financial terms?

Reliability of social capital – If there were to be another change in care could the same level of support be expected again? What are the limits?
Are there any other comments or questions that you want to make before we finish?

Appendix 3 Cohort Two Participant Information

- a. Participant Information Schedule
- b. Consent Form
- c. Interview Schedule



Participant Information – Cohort 2

Project: The Role of Social Capital in the Personalisation of Care
Investigator: Nick Willmore
Sponsor: University of Birmingham
Course: Doctorate in Business Administration

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. At no time will participation in the study, or choosing not to do so, have any impact on your professional position.

What is the study about?

The study is looking at two things with a common link. Firstly it is trying to establish if the support required by people is influenced by their existing networks and if so is it different for different groups of people? Secondly does the support provided to people with a learning disability have to be more expensive because they receive less natural support and so carers have to be more pro-active when supporting them?

In 2009 the Government announced that there was to be a transformation of social care in which individuals and their families would be able to take control of their care resources and arrange their own support. The early pilots showed that this was a way for the cost of state funded care to be reduced without cutting care. Indeed for many it resulted in an improved quality of life. Since then the resulting arrangements have not been as promising, so the question is why not. The study is taking one aspect behind the way that people organise their support (their normal relationships,

friendships and community links) and investigating what the real impact this has on individuals.

Risks and benefits

The study does not involve any changes in care arrangements and is not linked to the assessment that the local authority undertakes for any individuals. The approach will involve a discussion around the local policies and procedures and is intended to challenge these. It is not intended to challenge individual decisions or individual practices or the officers involved in these.

The benefits are similar to many of these studies in that participants report that it is helpful talking about local practices as they can gain an insight into how to better organise things in the future. Good professional practice involves an element of reflection, something that is rarely given time for in a busy service, but is part of the narrative approach. Each person gets something different from this sort of experience, but it is unusual for someone to get nothing back.

How will the study work?

The study has involved interviews with people who receive funding from local authorities; some have a learning disability, others are older adults. They were selected at random by the host local authorities and their agreement sought to participate in the study. It is now considered pertinent to reflect on the result of these interviews with the involvement of staff who set up care packages.

The interview will take place in a venue of your choice and will take 45-60 minutes. At the start of the interview the researcher will ensure that you understand what is involved and ask you to sign the consent form. The interview will loosely follow a prepared list of subjects, but will be guided by you. To ensure that the interview is accurately captured it is proposed that it is recorded on tape and then transcribed into writing. As a participant you will be offered a copy of the written record or the audio recording; the choice is yours. You will be asked to check that it is accurate as far as you can recollect.

What happens next?

After the interview the researcher will be bringing together all the interview results and looking for common themes. This will then be set out in a report that forms part of the final thesis. This draft report will be sent to you to comment on. It is possible that in the report there will be quotes taken from individual interviews to be used in the final thesis; this will be highlighted to the individual(s) concerned.

What about the people already interviewed?

The people interviewed have come from two local authority areas and were contacted at random. The researchers do not know who was invited to participate and the local authorities do not know who took up the opportunity. Therefore the contributions are to all intents and purposes anonymous.

What consent am I asked for?

In giving your consent to be interviewed you will also be giving your agreement that what you say can be used anonymously in the final report and thesis.

What personal information is held?

The final thesis will be available to the public so, in the reports it is based on, no information that could identify you will be included.

The records of interviews and other documents used in the study will refer to individuals by their initials. In order to manage the study there will be a master key, which will include all the contact details relating to participants and the initials used to identify your interview elsewhere in the study. This makes it very difficult for someone other than the researcher to link individuals and the comments they might make. The master key will be kept in a secure electronic file separately from the interview records.

The study is being undertaken by a part-time student who also runs a social work business, IAC. The study records will be held on a secure server owned by IAC. Only the researcher will have access to the records and the master key referred to above. This is a practical response to living in Sussex with the university being in Birmingham.

A year after the study is completed the master key will be destroyed so no-one will be able to identify the participants. The records of interviews will be kept for ten years in case anyone wishes to review the conclusions of the study.

Contact details

For further information on the study, what is involved and the arrangements relating to participants the researcher can be contacted as below.



|
To verify the authenticity of the researcher or the study please
contact the Health Services Management Centre at the University of
Birmingham.

*Thank you for considering participating in this study and I hope to
meet you in the near future to take it forward.*



CONSENT FORM

Project: The Role Of Social Capital in the Personalisation of Care
Investigator: Nick Willmore
Sponsor: University of Birmingham
Course: Doctorate in Business Administration

Please initial box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.
3. I agree to take part in the above study.

Please tick box

4. I agree to the interview / consultation being audio recorded
5. I agree to the use of anonymised quotes from my interview in publications, reports and the final thesis relating to this study.
5. I agree that my data gathered in this study may be stored (after it has been anonymised) by IAC Ltd for the purposes of the research and any future questions relating to it.

Yes

No

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Interview Schedule – Commissioning and care management staff

Target Group

Practitioners, team managers and service managers responsible for the assessment and service planning of individual packages of care

Approach

The interviews will be undertaken using a narrative approach that encourages a free discussion of the key issues but will allow participants to consider associated subjects where they believe it is relevant to the topic. Participants will be given a copy of the key questions that will form the subject of the discussion and then asked open questions to initiate their reflection on each of them. Secondary questions will be asked to either clarify comments or to encourage further depth in the answer.

Each interview should take between 45-60 minutes and will be recorded to facilitate an accurate transcript of the interview.

Key questions

The interviews will be loosely structured around the following questions:

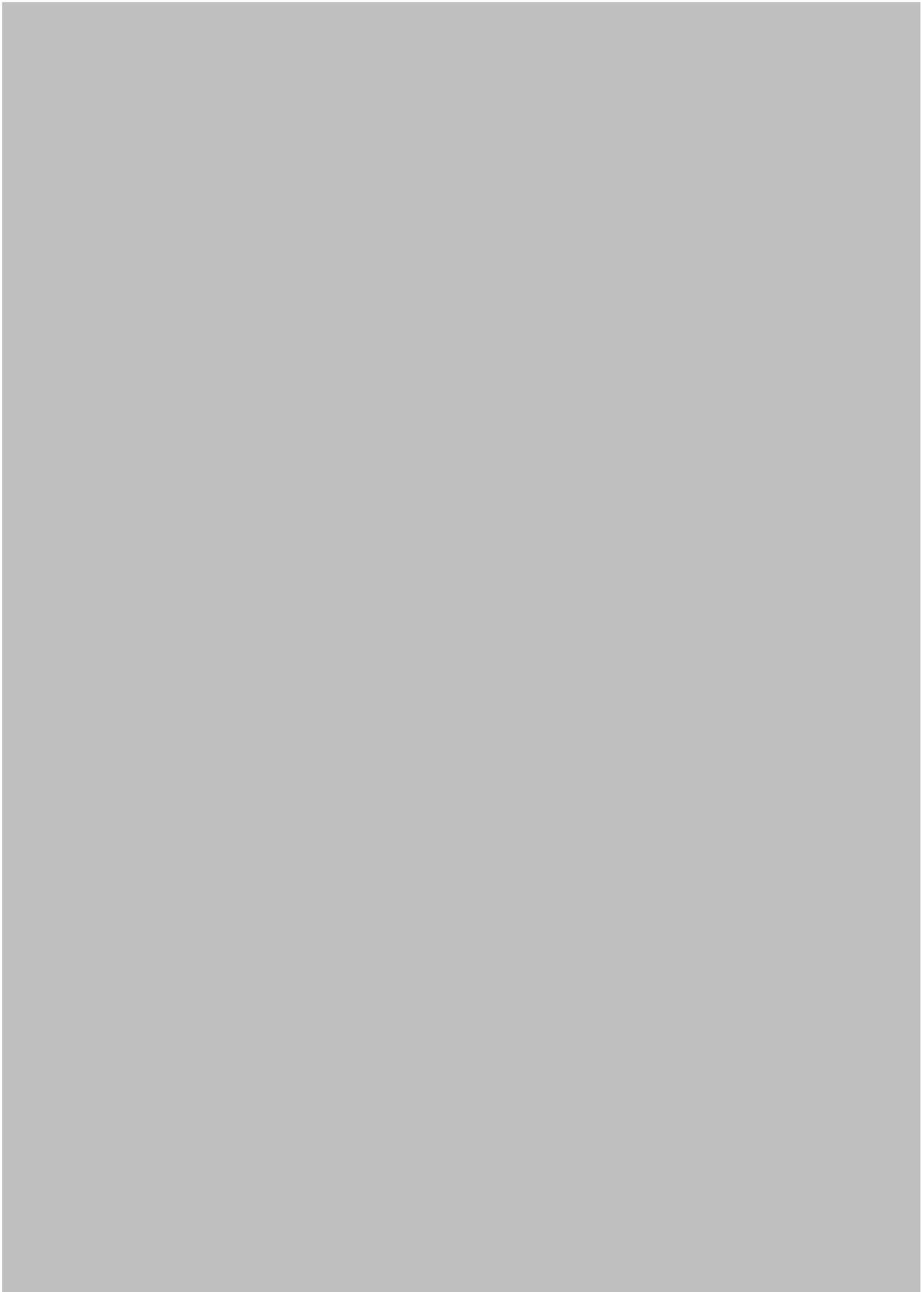
1. Is there a discussion in the service that employs you about social capital (the supportive networks between family, friends and communities of interest)?
2. Do local policies and procedures recognise the role of supportive networks beyond that of the immediate carer?
3. If so, how are supportive networks encouraged or hindered by local or national policy?
4. How do you identify and record the engagement of families, friends and a persons' wider community? Is this effective?
5. In what way have you been able to involve a wider network in the arrangement of a care and support package?
6. Has it been possible to give a specific financial figure for what the wider group of friends and family contribute and is this then collated by the commissioners?
7. Have you experienced people receiving support from family or friends that results in a different but effective approach to the delivery of care and support?
8. Do you expect to see any changes in the role of the wider family and community contacts in supporting people to access care and support in the future, if so in what way?

Appendix 4 Research Ethics Approval

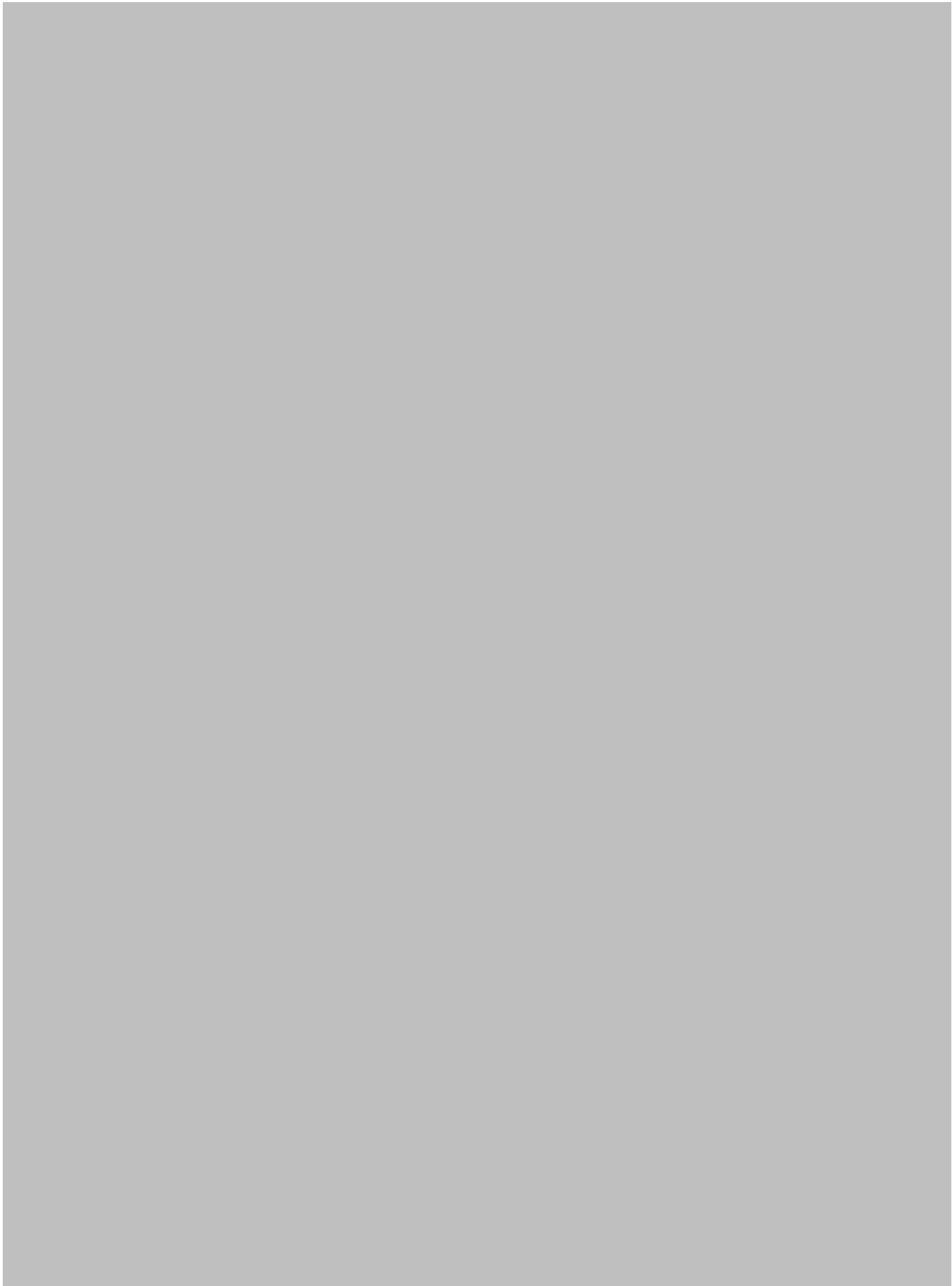
- a. Decision letter 3 April 2012

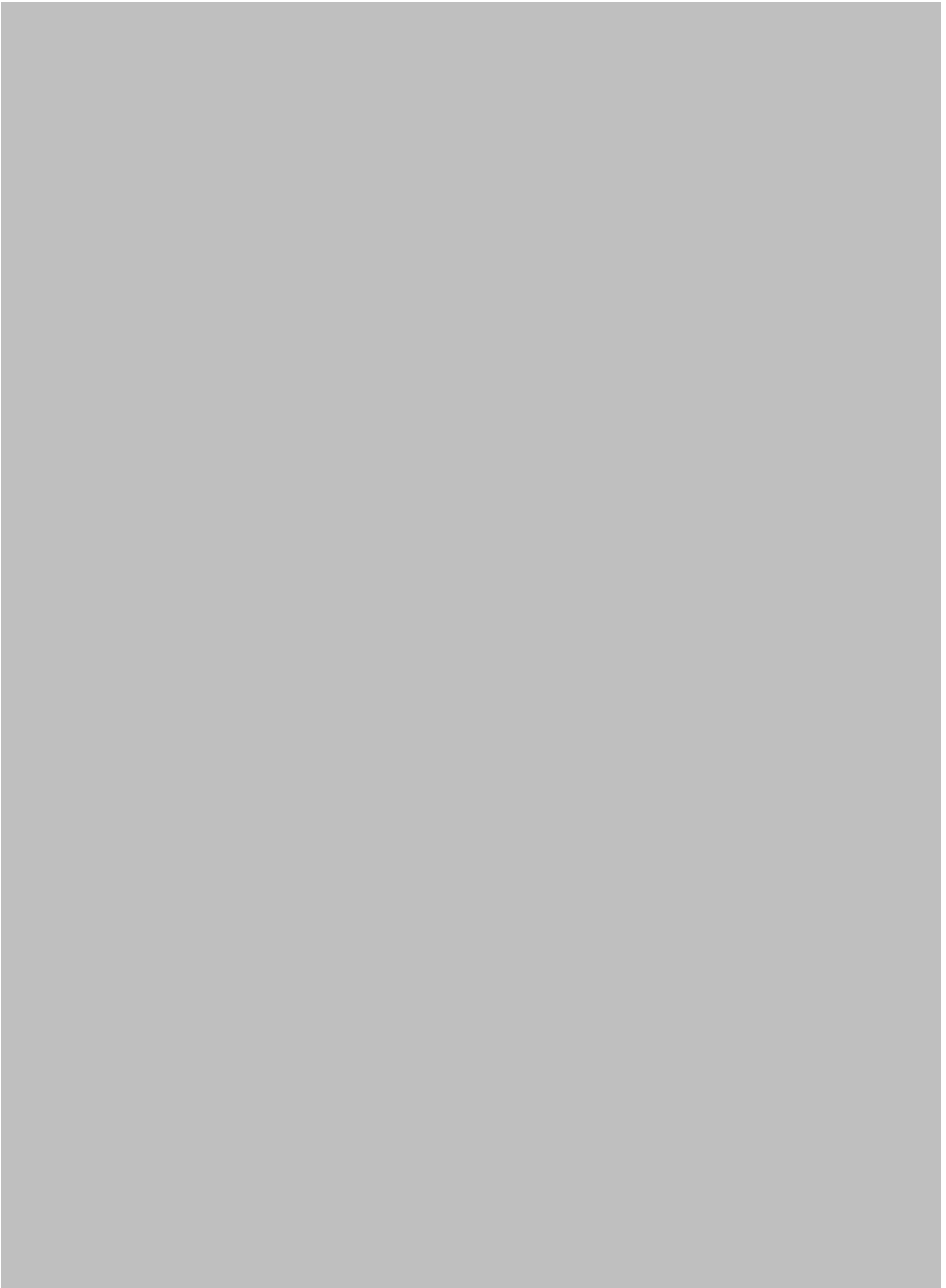
- b. Decision letter 19 June 2015















Appendix 5 Search terms

The table shows the majority of the search terms used during 2016 in the completion of this thesis. There is no record of terms used prior to this so is only a guide as to how information was being accessed during the write-up stage. Some terms used are a repetition in order to spot new material or changes in search results.

Search terms	Month accessed
Narrative research methods	Jan-16
Narrative research definition	Jan-16
Innovation Killers Christensen	Jan-16
Policy Implementation Theory	Jan-16
Street-level bureaucracy Lipsky	Jan-16
Austerity, personalisation and the degradation of voluntary sector employment conditions	Jan-16
The facets of social capital	Jan-16
policy implementation theory UK	Jan-16
Harald Saetren	Jan-16
Susan M Barrett	Jan-16
Whatever happened to policy implementation	Jan-16

Lipsky Street Level Bureaucrats	Jan-16
Aaron Wildavski implementation	Jan-16
Understanding street-level bureaucracy	Mar-16
Hudson Lipsky street level bureaucracy	Mar-16
New Public Management	Mar-16
New Public Management Hood	Mar-16
Anhier social capital	Apr-16
social network analysis	Apr-16
Care Act England	Apr-16
Austerity social care	Apr-16
care act 2014	Apr-16
care act summary	Apr-16
caring for our future	Apr-16
Care Act history England	Apr-16
Care and Support Bill history England	Apr-16
UK wage reduction	Apr-16
Care Act guidance	Apr-16
Judicial reviews social care number	Apr-16
judicial review community care	Apr-16

judicial review requests community care	Apr-16
UK number judicial review requests community care	Apr-16
UK number judicial review requests social care	Apr-16
UK number judicial review decisions	Apr-16
Royal Commission social care	Apr-16
Dilnot Commission social care	Apr-16
Securing good care for older people	May-16
Best value duty	May-16
Care management cycle	May-16
Changing lives	May-16
Valuing People	May-16
Valuing People Now	May-16
Our Health Our Care Our Say	May-16
Reablement	May-16
Reablement history	May-16
value informal care England	May-16
Carers Act	May-16
Dynes social capital disaster response	May-16
social care recording systems	May-16

case recording in social work	May-16
social care recording	May-16
social work recording systems	May-16
social work recording impact	May-16
social work recording practice	May-16
social work information management	May-16
Adult social care spend	May-16
Coleman social capital	May-16
define epistemology	May-16
Foundations of social theory	May-16
Bowles Gintis social capital and community governance	May-16
social capital social care	May-16
Peter Beresford Whose Personalisation	May-16
Kingston judicial review	May-16
West personalisation	May-16
Layton personalisation	May-16
Layton Irrational Exuberance	May-16
Narrative Approaches to case studies	Jun-16
social philanthropy	Jun-16

Social Entrepreneurship and philanthropy	Jun-16
Department of Health 1989 Caring for People	Jun-16
Putting People First	Jun-16
Social care budget reductions	Jun-16
health and social care budget	Jun-16
AusterityAusterity social care UK	Jun-16
social care funding	Jun-16
social care funding cuts	Jun-16
social care spend 2020	Jun-16
Fair Access to Care standards	Jun-16
social capital	Jun-16
social capital personalisation	Jun-16
UK social care self funders	Jun-16
Community capital and social care	Jun-16
Lane principal agent public sector	Jun-16
Lane public sector economics 2005	Jun-16
Becker rational choice theory	Jun-16
Duffy Gillespie personalisation	Jun-16
Duffy Gillespie professional gift	Jun-16

Duffy Gillespie community capital	Jun-16
Bourdieu social capital	Jun-16
Principal agent theory	Jul-16
Social care quality	Jul-16

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