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ORIGINAL ARTICLE

Normative puzzles for local government: Managing the introduction of single-handed care in England

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Abstract

A crisis in social care is apparent across the developed world as ageing populations put unprecedented demand on understaffed social care workforces. A recent popular response to this 'care crisis' within the UK involves the 'innovation' of single-handed care (SHC). SHC involves a care package with two or more homecare workers being reduced to one worker using advanced equipment and new moving and handling techniques. In this article, we explore how SHC is rendered in 245 documents from 52 local authorities in England. Using Actor Network Theory as an interpretative lens, we suggest documents attempt to satisfy three 'duties of care': to the individual wellbeing of citizens, morally and fiscally to the collective and to innovation. Each appeal to different stakeholder groups necessary for SHC to work, but the combination of duties can pose problems in enabling coherent stories of SHC. Duties can be kept apart in different documents, but at times they must be brought together in certain textual spaces to enact SHC as a coherent enterprise. Here, the potential tensions that emerge are routinely orientated to as (merely) problems of process that can and should

be managed in and through a more refined approach to change management.

KEYWORDS
actor network theory, document analysis, homecare, local government, single-handed care, social care, United Kingdom

BACKGROUND

The social care systems of developed countries across the world are facing common challenges (Robertson et al., 2014). The rhetoric is familiar: a rapidly ageing population, people living longer with multiple chronic conditions and a social care workforce that cannot keep up with demand. In the United Kingdom, the development of a coherent strategy for the future of social care is a task that has vexed successive governments. Despite inertia from national government, UK local authority social care services have not stood still and have continued to deliver, develop and innovate. One such innovation is the implementation of 'single-handed care' (SHC) within the last decade or so, which is a potential ameliorator for several key social care challenges. A recent survey of 76 English local authorities found that, in 2019, 44% employed projects dedicated to exploring SHC within their area (Whitehead et al., 2022).

The premise of SHC is that the provision of technology (equipment) and advanced moving and handling techniques means that work previously done by two homecare workers (double-handed care [DHC]) can now be done safely by one. Case studies of local authorities employing SHC projects have found DHC to SHC 'conversions' for 25%–44% (Phillips et al., 2014), 17%–44% (Harrison, 2018) and 28% (Agnew, 2019) of citizens in receipt of DHC. The benefits of SHC are positioned as threefold. First, cost savings. English local authorities spent almost £4.5 billion on adult homecare in 2020–2021, either providing/paying for homecare themselves or providing payment to citizens to pay for their own care through the UK's 'direct payments' system (Social Care Statistics Team, NHS Digital, 2021). With SHC, whilst initial investment in equipment and staff training may be costly, these can begin to pay themselves back quickly through the reduction in the need for a second care worker. One report exploring the effectiveness of SHC in one local authority suggested that for every £1 invested in SHC there was a return in savings of £2.41 (Agnew, 2019). Second, SHC increases the supply of homecare workers to meet the high demand from the social care system, with the same report finding that from almost 100 cases of DHC reviewed there was a saving of approximately 215 extra care hours every week that could be deployed elsewhere. In addition to hours saved in direct care, SHC can be more readily deployed than DHC for citizens being discharged from hospital, thus freeing up capacity within the health service through reducing 'bed blocking' and lessening the likelihood and impact of disjointed care. Third, SHC is proposed to offer improvements in quality of care for citizens. This is framed in terms of facilitating improvements in wellbeing as citizens become less dependent on homecare workers and regain more of their own (technology-assisted) agency, as well as an increased dignity and privacy.

However, the multiple solutions offered by SHC cannot necessarily be brought together into a neat singular narrative. Indeed, this article takes as its premise the notion that SHC is rendered differently depending upon the particular challenge it is being employed to resolve, which often varies depending upon the stakeholder. A local authority finance committee trying to balance

budgets might have different priorities for SHC than a family member trying to get the best care for their relative. But for SHC to function there must also be common ground that draws these together into a single project of parts that, at moments, cooperate.

This article explores how SHC is enacted in documents produced by English local authorities. These include agenda documents and minutes from local authority committee meetings, financial reports, strategy documents, service specifications, market position statements, equality reviews, job advertisements, training notices, presentation slides, website press releases and newsletters, amongst other types of document. Drawing on the tenets of Actor Network Theory (ANT) and beyond, its aim is to explore how local authorities perform the multiple renderings of SHC required to involve the various stakeholders within the social care system whilst also bringing them together into a single common project. This document analysis is part of a wider project exploring the introduction of SHC into English local authorities. The project included a survey and interviews to explore current practice, alongside co-design work to develop and test recommendations for how local authorities should review homecare packages with multiple careworkers.

Enacting multiple modes of care

Muusse et al.'s (2021) ethnography of a community mental health team outlined, following Law (1994) and Moser (2005), multiple modes of ordering care. They describe how people move between different modes (like 'a relational approach' or 'bureaucratic accountability') and show how '[e]ach mode of care describes a specific way of defining what the problems is, the solutions to it, and how this aligns with a specific notion of good care' (Muusse et al., 2021, p. 1585). Such ANT and 'post-' ANT thinking emphasises that different knowledge practices produce multiple different objects of the same, singular object, and that coherence is actually dependent upon the enactment of separate multiple versions of the object that might not cohere (Law, 2002, 2004; Law et al., 2014; Mol, 2002). Mol (2002) notes that:

> The relative scarcity of controversy in daily practices, where so many different objects go under the same name, is likewise a remarkable achievement. It is a result of distribution. It comes from keeping divergent objects apart if bringing them together might lead to too much friction.
>
> Mol (2002, p. 119)

Mol shows how different modes of ordering (care of) atherosclerosis is distributed, for example, over organisational space, in different departments of the hospital. At times they come together, such as when a test result or a pressure measurement is in contrast with a patient's report about pain when walking. At such moments, a careful process of negotiation must be employed, where the multiple elements necessary for the enactment of the disease can be made to cohere. For example, the (mundane) practicalities of doing pressure measurements are highlighted and so such (objective) results are problematised. It is the work that is done in these spaces of negotiation that are crucial to determining whether the necessary simultaneity of multiplicity and singularity of the object, or what has been referred to as an object's 'fractionality' (Law, 2004) or 'syncretism' (Law et al., 2014), is successfully achieved or not at that moment. This article explores how documents produced by English local authorities serve as textual spaces of justification for competing orders of what doing SHC is (Boltanski & Thévenot, 2006). These documents

perform the multiple renderings of SHC required to involve the various stakeholders within the social care system whilst also bringing them together, at crucial moments, into a coherent project.

METHOD

Data collection

An Internet search was performed in April 2020 using the search engine Google in order to identify local authority texts that made reference to SHC. This search strategy offered a convenient way of accessing local authority texts for analysis. The search was conducted in domains ending '.gov.uk' using the terms 'single-handed care' (with and without a hyphen), 'single-handed homecare' (with and without a hyphen) and 'moving with dignity' (an alternative term for local authority single-handed homecare projects). In addition, relevant documents and webpages identified through informal web browsing were included. Webpages and files were saved as PDF files. A decision was made to include documents only for English local authorities (rather than UK-wide), reflecting the devolved nature of governance of adult social care within the UK (with Northern Ireland, Scotland and Wales having separate governance). Documents were included only if they could reasonably be assumed to have been produced by any of the 151 English local authorities with adult social care responsibility or in partnership with other organisations such as the NHS.

After removal of duplicates, a total of 245 texts were included from 52 local authorities, of which 34 texts were identified through informal browsing. One of these local authorities was abolished in 2019. Of the remaining 51, each local authority spent a median of approximately £23.5 million on adult homecare in 2020–2021 (interquartile range from £17.4 million to £43.0 million), with a diverse range from £3.5 million to £116.4 million (Social Care Statistics Team, NHS Digital, 2021).

Ethical approval for the study was obtained from Northumbria University.

Data analysis

The three authors independently pilot-coded a sample of seven documents each, based upon the general principles of thematic analysis (Braun & Clarke, 2012; Merriam & Tisdell, 2016) in order to identify how SHC was rendered in the text being examined. Whilst most of the sample documents were unique for each author, a total of four were overlapped. The authors then compared and discussed their findings, before engaging in another round of independent pilot-coding of an additional sample of 12 documents each. As before, most of the sample documents were unique for each author, but a total of six were overlapped. After this second round of pilot-coding, the authors compared and discussed their findings again, before agreeing a common coding structure. The first author then used this to deductively code all of the texts; subsequent modifications were made, in consultation with the other authors, if the structure could not accommodate the text being coded. Texts were coded using the computer software *NVivo 12*.

A final note is that there are various terms used within UK social care, and more widely within English local authorities, to refer to people who use social care services, including 'service users', 'customers' and 'residents'. Each carries with it a social and political context concerning the position of people relative to others. In this article, we use the term 'citizens' unless they have been specifically identified otherwise within the particular quotation presented.

FINDINGS

A website press release from one local authority ('council') shows a number of ways in which SHC is rendered:

> One of the great benefits of this approach is that on some occasions where we would have traditionally needed two carers, the support of one carer is more than sufficient. This is great news for us as we know residents are happy because they feel more in control of their own lives and it means we can free up staff time to visit other residents and carry out other essential duties.
>
> Extract 1: *Dudley Council—Greater Independence for People in the Home*

The local authority presents SHC as offering two 'great benefits'. First, SHC gives autonomy to 'residents' who now 'feel more in control of their own lives'. This satisfies a duty of local authorities to not only care for but *empower* the individual citizen. Secondly, SHC helps local authorities to manage their systems and balance budgets through 'free[ing] up staff time'. This is also an important duty, often expressed as a need to maintain the order of the system for the benefit of all. In this example, there is also an emphasis on how the individual benefits from this—staff can now 'visit other residents and carry out other essential duties'. A third rendering of SHC is more implicit—that of the duty to (responsibly) innovate. SHC as an innovation breaches what is 'traditionally' done, and is 'more than' sufficient to meet care needs. Yet it will only be employed 'on some occasions', as carefully and realistically applied rather than a blanket cost-saving diktat.

This example shows three core narratives that are embedded across the archive: 'individual wellbeing', 'moral and fiscal responsibility' and 'responsible progress and innovation', and the work that is done to weave them together into a common story of SHC. In the following sections, we outline each narrative more fully. We then show how they, at times, overlap in renderings of SHC and how such overlap is managed. Centrally, the tension or 'frictions' that emerge as the different orders are (briefly) brought together in the archive are routinely orientated to as (merely) problems of and for mundane change management techniques with a focus on the effective management of, disruptive but to be expected, behaviours.

Enabling individual wellbeing

In the UK, the Care Act 2014 stresses that issues of autonomy, personalisation, privacy and dignity are all inextricably linked to the person's wellbeing. SHC is often framed in terms of such language. This narrative is found across the documents, but most prominently in public-facing documents such as press releases and information leaflets. An information leaflet on SHC outlines that:

> We know from other areas [that] people who are now cared for by a single care worker with better equipment feel that they have more independence, choice and control, a better relationship with their care worker and more dignity and privacy. For some people, it will enable them to be cared for safely by a relative for longer if that is their choice.
>
> Extract 2: *Sefton Council—Moving with Dignity*

The quest(ion) of autonomy is central here and this extract stresses that SHC offers 'more' of it—'more independence, choice and control' to those cared for, alongside 'more dignity and privacy'

within which individual autonomy can exist. This 'more' can also mean potential for autonomy to be (re)embodied within individual bodies, with one website press release noting that 'the equipment is already helping people to maintain their mobility for longer, and have greater control of their movement as well as increasing bone density and strengthening muscles' (*Dudley Council—Council Approach Hailed as Best Practice*). SHC is rendered as not simply about the local authorities giving help to citizens but as 'helping people to do more for themselves'. In Extract 2, citizens are rendered as able to relate better to a single care worker, which elsewhere is linked to the increased intimacy of a one-on-one relationship. Another document also notes that SHC 'would increase the likelihood that [citizens] are able to have their preferred carer at a time that suits them' (*Brent Council—Adult Social Care in Brent* [public report]), meaning SHC offers more control in relation to both when care will be delivered and who will be delivering it (see also the 'choice' of citizens to be cared for by family members in Extract 2). In these examples, we see how the tenets of personalisation, person-centredness and dignity are enfolded into the SHC narrative of individual wellbeing centred around autonomy.

Following Goffman (1981), in Extracts 1 and 2, local authorities position themselves as *animators* rather than *authors*, relaying messages about SHC from citizens as the apparatus through which the autonomous citizen author expresses their voice. This serves to show the value of SHC whilst also reflexively demonstrating the value they place on such lay expert knowledge. However, problems arise when the strength of duty to citizen autonomy mean more 'direct' animation of citizens' voices is called for, such as in documents related to public consultations. For example, one document includes verbatim comments from different citizens about a proposed SHC programme:

> I wouldn't feel safe with one care worker and I think accidents may happen
>
> I feel I would not be able to remain at home because I wouldn't be getting the care I need, it is very important to me that I remain at home for as long as I can with the help from my carer workers
>
> Just the thought of having one care worker ups sets [sic] me very much
>
> I am a nervous person and having one carer I think my health would deteriorate.
>
> Extract 3: *Tameside Metropolitan Borough Council—Establishment of a Single Handed Care Team Following Consultation*

In such moments, we see a new version of SHC emerge where the idea of implementing it in light of these expressions of choice means SHC as autonomy-*reducing*. However, this apparent counter-narrative is itself orientated to within the same document since 'there will be no insistence on change' (see also the 'on some occasions' in Extract 1). Across the archive, this tension is more commonly managed by framing objections as a normal, transitory reaction to change. The same report Extract 3 is from thus notes that '[e]xperience elsewhere is that with reassurance and fully informed, fully involved decision-making, some people will feel able to change'. Citizen objections are framed as potentially malleable rather than statements of choice, and far from citizen autonomy being overridden their autonomy is actually positioned as essential to this change since it requires citizens being 'fully informed' and 'fully involved' in discussions. However, the tension noted above becomes particularly apparent when local authority staff are rendered as 'persuading' citizens, with one job advert for a local authority occupational therapist (specifically assigned to a SHC project) looking for 'persuasive skill when working with people who may have been having carers for some time' (*Stoke on Trent City Council—Senior Occupational Therapist*

Level 1 [010934]—External). Acts of reasoning, inclusion and reassurance can be heard as part of the repertoire of 'persuasive skills', but it is also hearable as having the potential to be less autonomy-respecting.

However conceived, there is never a direct position of 'insistence' in this narrative, of unilateral decision-making. Instead, SHC will only be right for 'some people'. Subjugation of citizen autonomy never emerges as clear-cut but as an opaque possibility as part of negotiations orientating the pragmatic textual activities of local authorities in their rendering of SHC with their duty of granting citizen autonomy.

Satisfying moral and fiscal responsibility

Alongside the individual wellbeing narrative, we also see a narrative that focuses on rendering SHC as enabling efficiencies at the level of the local health and social care system to maximise the common good of all. It is most prominent in documents tied to oversight by local authorities, particularly in discussions around fiscal responsibility. A *Report to the Overview and Scrutiny Committee* of one local authority outlines that '[r]emedial measures to enable the Adult Social Care service to achieve a balanced budget will include the development of projects including Double to Single Handed Care' (*Sefton Council*). Here, SHC is part of a suite of 'remedial measures' that focus on managing a problem of an unbalanced budget. However, for local authorities the orderly and careful (re)organisation of the systems of homecare goes beyond questions of finance to include organisational issues of productivity and the workforce:

> It was noted that recruitment to and retention of staff in the domiciliary care sector was difficult[,] therefore staff resources and skills in enabling people and reducing double handed care was key and this was planned through the introduction of "Smarter (single handed) Care" training and supported recruitment.
>
> Extract 4: *Telford and Wrekin Council—Health and Wellbeing Board Minutes 6 June 2018*

Health and Wellbeing Boards, established in local authorities through the Care Act 2014, operate at a strategic level and seek to integrate local health and social care systems. In such a context, SHC is a potential strategy the Board can advocate to ameliorate the problem of 'recruitment [...] and retention of' homecare workers, an issue that creates problems of market fragility in homecare providers across the country (Bottery, 2018, 2019). Here, 'reducing' the supply and demand of one form of care—double handed—for 'Smarter (single handed) Care' is a 'key' solution. As we saw in Extract 1 (above), increasing capacity can 'free up staff time to visit other residents and carry out other essential duties'. In contrast to the narrative of individual wellbeing, rather than emphasising individuals, in Extract 4, the entity of interest is the 'domiciliary care sector'. However, this focus on a wider system does not have to be at the expense of the individual. As one document notes: 'Every [single-handed] care package safely provided for one person means another carer is available for someone else' (*Wokingham Borough Council—Council Increases Investment to Support Residents in their Homes* [website press release]).

SHC is also positioned as an approach to help another (ongoing) problem facing local authorities: delayed transfers of care (DTOC). DTOC refers to a delay in transferring patients' care from in-patient hospital to community-based settings, and more timely transfers enable increased capacity in the (scarce) resource of hospital beds. The national strategy to manage DTOC is to

better integrate the various actors within the local health and social care system to establish a more efficient system that can be measured via performance indicators like 'days lost to DTOC' (*Derbyshire County Council—Public Document Pack for Meeting of Health and Wellbeing Board 11 July 2019*). This is a key priority for Health and Wellbeing Boards—it is one of a suite of performance indicators they are engaged in. Such reductions in DTOC align with the national government *Better Care Fund* programme, which seeks to support the integration of local health and social care. This a common source of funding for SHC 'projects', and SHC can be rendered as an important strategy within this DTOC narrative:

> This OT [occupational therapist] is focussed on working with hospital staff and the person regarding single handed care to ensure that people are not delayed from being discharged from hospital due to unnecessary double up packages being requested.
>
> Extract 5: *Peterborough City Council—Progress Report to the Adults and Communities Scrutiny Committee*

Here, there is a 'focus' on the three actors—the occupational therapist, hospital staff and the person being cared for—working together to reduce DTOC. In this way, SHC is rendered as supporting local health and social care systems to act more efficiently through better integration of its parts to remove 'unnecessary' work and so to maximise the care they offer.

However, not all parts of the system can necessarily be presented as working smoothly together. Some documents render a fragmentation between local authorities and homecare agencies, the 'providers':

> Without the openness to change and work differently by providers, the savings and future avoided costs will not be realised. Incentivising the providers will be in the form of provision of training, backfill funding for training and costs of additional review and risk assessment activity incurred for the provider with each of the 800+ existing services users in receipt of 2 carer packages of care.
>
> Extract 6: *Lancashire County Council—Service Challenge Savings*

Homecare provider agencies are here presented by this report on budget savings as the problem to smooth functioning due to a lack of an 'openness to change and work differently'. Yet, whilst rendering this as a problem, a solution is nevertheless readily offered: through managing the 'change' faced by providers. This requires 'incentivising'. Local authorities are aware that providers have different motivations and systems of working, including specific moving and handling policies and procedures that may not concord with those of the local authority. As with the first narrative, we see a negotiation to establish fractionality of being able to mediate between a requirement to acknowledge multiple independent actions of the various local health actors whilst satisfying a duty to increase efficiencies through integrating those actions into a single system.

Responsible progress and innovation

Whilst the above two narratives capture an explicit sense of *justification* for SHC through highlighting the benefits to the individual and/or the local health and social care system, this third

narrative focuses on the practical mechanics of replicating SHC as a technique. It is found across a range of document types, with a greater presence in those concerned with implementation issues. For example:

> Adult Social Care organised an event to share and promote the use of technology, equipment as well as techniques required for single handed care. People who need to be hoisted or cared-for in bed usually require a double-staffed care package. In the last few years, innovations in moving and handling practice mean that with the use of technology, equipment and training a single carer can provide care safely on their own [...]. Over 150 people from across the NHS, Care Providers and Adult Social Care front line staff [attended]. In total, 90% of attendees have stated that they will implement their learning. Similar events are planned in the future.
>
> Extract 7: *Westminster City Council—Briefing to the Family and People Services Scrutiny Committee*

This example captures a number of aspects of the third narrative. The distribution of knowledge is integral and 'shar[ing]' and 'promot[ing]' this (new) knowledge about the 'technology, equipment as well as techniques' embedded in delivering SHC is key. Recent 'innovations' mean SHC can (now) be enacted 'safely' by those with the appropriate 'technology and equipment' and cognitive resources gained through 'training'. The event is rendered as a success: '90%' of attendees recorded that they 'will implement their learning', with knowledge having reached a wide range of stakeholders, such that the department plans to deliver such events again.

Within this narrative, SHC as an innovation is a taken-for-granted good. The focus is on enabling an effective introduction, embedding and sustaining of it over time. This implementation work focuses on managing culture change on how to effectively 'share and promote' SHC. Training events such as 'SHC workshops' aimed at care providers (*Norfolk County Council—Care Providers News Archive*) seek to enable 'delegates' to develop the skill to undertake specific tasks like '[i]dentify[ing] which customers are appropriate for single assist care' or '[r]ecommend[ing] single assist techniques for supporting a person from sitting to standing'. They are to develop a specific professional vision (Goodwin, 1994) that can begin to see with more certainty, 'identify' when SHC is 'appropriate', as well as make sense of, speak for and 'recommend' the new technological-mediated 'techniques' (*Norfolk County Council—Care Providers News Archive*). Implementation work also includes local authorities proposing SHC-specific staff and groups that can act as a champions and role models. Another document noted that a new 'dedicated singlehanded care team' could enable 'coaching of internal and external staff, promoting culture change and thinking, and providing a critical expert capacity' (*Lancashire County Council—Service Challenge Savings*). Training in the form of workshops positions SHC more as a technical problem of practice to be managed through dissemination in the limited spatio-temporal framework of a workshop. However, the introduction of devices such as a dedicated team that can provide coaching, promotion of SHC and 'critical expert[s]' reflexively demonstrates an awareness of the potential complexity of such a change, namely that this may not be without resistance.

This third narrative explicitly enacts such resistance as implementation problems with concomitant mitigations, such as it being attributable to a historical 'perception [...] that many care and support interventions which require manual handling can only be delivered safely through the provision of two carers' (*Tameside Metropolitan Borough Council—Establishment of a Single Handed Care Team Following Consultation*). This might be mitigated through strategies such as a team to model and support culture change, direct financial 'incentivising' of care

providers through covering additional short-term costs like backfill 'funding for training and costs of additional review and risk assessment activity incurred' (*Lancashire County Council—Service Challenge Savings*) or (as per the first narrative) approaching resistance as a temporary stage in a process of change.

In these situations, the potential objections of particular stakeholders, be they staff unconvinced by the benefits of SHC, homecare agencies worried about financial implications or citizens unhappy about changing their care package, are aligned with the narrative of progress and innovation through being framed as implementation problems that can be mitigated. However, as has been suggested in other sections, such alignment is precarious and by no means clear cut. Whilst one document discussed above emphasises the correction of traditional misconceptions that SHC is often unsafe, the very same document must also render a legal concern that such safety risks may be present, noting 'the risk of claims arising out of this change which could prove counterproductive to savings proposed' and that the 'Council's insurers should be involved in the implementation stage process' (*Tameside Metropolitan Borough Council—Establishment of a Single Handed Care Team Following Consultation*). Rather than only rendering such concerns around safety as misconceptions, the necessary mobilisation of legal stakeholders in the implementation of SHC requires these risks to also be constructed as a serious concern, presenting a problem of negotiating a coherent story that also maintains the message that such concerns are historical myths.

Managing multiplicity

As we outlined in the opening section, throughout the archive, the three core narratives we have discussed above can overlap. At times they can offer potentially contrasting visions of SHC, as the following example from the minutes of a care provider forum suggests:

> On the matter of whether the views of service users will be sought during the re-assessment, [name] clarified that re-assessments must reflect the person's views. However, the council has a duty to support people in the most cost-effective way given limited resources.
>
> Extract 8: *Tower Hamlets (LBTH) Adult Social Care Pan-Providers Forum—Key Notes*

We see here an essential tension embedded in local authority work between the maximisation of the good for each specific citizen and the maximisation of good for all citizens they serve. The duty to respect each citizen's individual autonomy ('the person's views', which the council 'must' reflect) are placed in contrast to 'the duty to support people in the most cost effective way'. It would seem that a singular story can only be maintained by selecting one of the renderings over the other. But a narrative of SHC without respecting individual autonomy, or one not satisfying the resource requirements of a limited health and social care system, is to perhaps risk a narrative that wouldn't cohere. Such tension is more explicit elsewhere in the documents, with '[r]esistance from service users and their families' defined as posing a 'risk' to the budget-saving potential of SHC (*Lancashire County Council—Service Challenge Savings*). In this document, the resistance could be 'mitigated' through promoting a positive message about SHC to citizens and their families. We have seen this type of work in the report from Extract 3, where people who are 'fully informed' and 'fully involved' are rendered as more likely to engage with SHC.

A similar conflictual overlap can be observed between the first and third narratives, where the championing of citizen autonomy provides a barrier to its practical enactment:

> Experience elsewhere is that with reassurance and fully informed, fully involved decision-making, some people will feel able to change [to SHC]. For people who have never previously required a manual handling transfer, adopting a single handed approach is less of an issue, not least because they will not have known anything else. It is in this respect that most of the change in practice will, over time, occur.
>
> Extract 9: *Tameside Metropolitan Borough Council—Establishment of a Single Handed Care Team following Consultation*

Whilst the first part of this extract emphasises the 'fully informed, fully involved' nature of citizens, in the very next sentence it is the very *lack* of knowledge that is beneficial to the implementation of SHC. Indeed, the fact that citizens newly referred 'will not have known anything else' but SHC is posited as a means by which the 'change in practice' towards SHC within the service is predicted to occur. Unlike the previous examples, there is a lack of a thread that draws the two narratives into a coherence, and whilst neither of the two narratives threatens to be rejected there is no (easily rendered) coherent story that is told when anything more than a superficial reading is applied to it.

DISCUSSION

The introduction and embedding of SHC in local authorities is a strategy that has the potential to help address some of the key challenges facing social care systems in developed countries; local authorities in the UK have taken a lead in employing it. Through examining how SHC is enacted within the documents of English local authorities, our findings suggest that the successful enactment of SHC requires local authorities to draw on and coordinate three key narratives of responsibility: a duty to enable individual wellbeing centred around the autonomy of citizens, a moral and fiscal duty to establish efficiency at the level of the local health and social care system, and a duty to implement innovation. In other areas of local authority work, other norms, duties and responsibilities may also be drawn on. Each of these normative positions are important as they appeal to key situations, processes and stakeholders necessary to successfully implement SHC.

The first duty was particularly apparent in public-facing documents. Enrolling the support of citizens through appeals to SHC as enhancing individual wellbeing is important to local authorities given their accountability to provide care to their citizens. More widely, the importance of the individual citizen is also encoded into legislation such as the Care Act 2014 that local authorities are obliged to follow, where '[p]romoting individual wellbeing' is a central tenet (Part 1, Section 1). In this sense, this duty is also entangled with broader legal obligations for local authorities.

The second duty is tied particularly to the processes and procedures of council cabinets, finance committees and management meetings, with SHC being presented as a mechanism for budget savings. It also aligns with a focus on enabling efficient health and social care system for all, as SHC potentially addresses homecare worker supply and demand problems. Whilst this can be regarded as appealing to a wide range of stakeholders, it is particularly so to local authority actors, such as council executives and senior and service managers, in their role as custodians of their local health and social care system. Moreover, the UK government has enacted legislation that incentivises and requests local authority actors to be involved in working to integrate their

local health and social care system to improve efficiencies, expressed in systemic targets such as the number of delays in transfers from hospital to a community setting (The King's Fund, 2018).

Finally, the third duty to implement innovation might be regarded as appealing on two levels. On the one hand, the notion of innovation offered by SHC gives a general promise of improvement, be that to the individual citizen's particular feeling of wellbeing or to a local authority manager's statistics on the efficiency of DTOC. The second level appeals to those directly implementing SHC—both within local authorities and the care provider organisations—offering encouragement, evidence and experience that the practices and procedures of SHC can and will enable their practice of care to function smoothly.

Notably, all three duties are situated within diffuse networks of potential situations, processes and stakeholders, including local citizens and local authority actors, alongside other statutory and private actors (e.g., care workers, central government civil servants) and other bureaucratic orders (e.g., legislation). In some local authority documents, only one element of a narrative of responsibility predominates. For example, documents on local authority financial budgets are almost exclusively interested in rendering SHC as a mechanism for addressing a fiscal duty of balancing budgets. However, most of the documents examined embed multiple elements of the narratives of responsibility within them. At moments, they coexist and align, supporting and enhancing each other—there is *coherence*. At other times, they do not necessarily complement one another—there is *non-coherence*. Within the examined documents, we saw two key non-coherences: (1) between a duty to the autonomy of the individual citizen and fiscal and moral duties to the system and (2) between a duty to individual citizen autonomy and a duty to innovate. Both of these might be seen as a variation of the contrast between a normative duty to autonomy and the constraint on autonomy that creeps in to acts of doing care (Hennion & Vidal-Naquet, 2016). In such cases, the authors of documents cannot simply dismiss one narrative of responsibility in favour of the other. Each narrative is important to making SHC work through appealing to particular situations, processes and stakeholders, yet for SHC to work it also needs to be rendered, at moments, as a singular story. It is in this sense that SHC must be 'fractional' (Law, 2004) or 'syncretic' (Law et al., 2014): a single story but one with multiple parts that do not fit together coherently.

Law et al. discuss various 'modes of syncretism'—ways of achieving this coherence of the non-coherent—and we see many of these apparent across our archive. For example, we see a form of what Law et al. term 'domestication', which involves outlining non-coherent parts and then, through a subsequent process, homogenising their differences so that a more coherent story can be made. In this way, citizen objections to SHC in (for example) a public consultation document can be rendered as a temporary reaction that will be resolved once sufficient understanding and reassurance takes place. Yet making present such citizen objections is also necessary to satisfy the duty to citizen autonomy, without which the enactment of SHC would be problematic. We also see, following Law et al., the syncretic mode of 'conflict' enacted, as in the clash between potential citizen objections to SHC and the need to implement SHC for financial reasons demonstrated within the minutes from a forum of care providers. Here, coherence is found in the coming together of differences in a common arena where these necessary differences can at once be rendered but simultaneously eliminated in the promise of future conflict resolution. However, such 'conflict' is not appropriate for public press releases, where instead any potential non-coherence of objections of citizen voices are not present, replaced by (for example) an elected council official who can speak for each individual, collectively.

This archive begins to demonstrate how local authorities work to manage normative puzzles in, through and as their documentary life. Notably, local and regional specificities—such as

variations in the concentration of the homecare workforce—as well as diversity in and between stakeholder groups are homogenised within and across the archive in relation to the enactment of SHC. SHC was the sole topic in some parts of the archive whereas in other parts it was embedded alongside other elements and topics of local authority work. For example, SHC could be but one example among many of ways that a council enacts the duty of fiscal responsibility. Importantly, in this way, this SHC work may be reflected on and orientated to in a broader view of local governance work. Thus, in some documents tied to financial budgets, we may see no explicit engagement with the duties of individual wellbeing, the responsibility to innovate or even the moral responsibility for ensuring efficiencies in the system. Instead, questions of, for example, citizen voice that could threaten to shape and disrupt the arithmetic logic of the financial figures can be distributed to other moments in the work of local governance, such as through the range of approaches to citizen participation in resource allocation (Ebdon & Franklin, 2006).

However, in other moments in the documentary life of local government, this distribution of non-coherent normative multiplicity to different textual spaces is not an option, and a mode of syncretism that can bring about a coherence of the non-coherence must be negotiated. For example, disjointed care, and particularly DTOC, are key problems for social care in the UK. They have received increased national attention during the COVID-19 pandemic with a need to discharge people from hospital more quickly (Limb, 2022). SHC offers to help this since there are more care workers to fulfil hospital discharge demands, and there is not the added difficulty of obtaining two care workers for a particular discharge. However, in moments in the archive, we see that homecare providers and their homecare workers are rendered as lacking an 'openness to change' and requiring 'incentivising'. The wider literature points to issues of market fragility and the problem of increasing numbers of providers going out of business or handing back contracts to local authorities (Bottery, 2019). So, different logics, such as those around acceptable workforce pay and conditions and the profitability to homecare providers could also be negotiated. Yet, within the SHC archive, such broader, structural issues are never directly engaged with, and instead only emerge as a (necessary) trace framed as a resistant mindset that can be overcome.

As recent work exploring the implementation of policy syncretically suggests (Davies & Lindvig, 2021; Mellaard & Van Meijl, 2017), we need to view SHC as an 'assemblage' (Deleuze & Guattari, 1983) of heterogenous elements that are in an ever-evolving relationship that 'moves' through different contextual spaces. In our archive, the different textual spaces create, at moments, a hegemonic version of SHC. Moments of non-coherence, the tension and frictions that emerge as the different orders are (briefly) brought together are routinely orientated to as problems of process, as problems of and for the logic of change management. Within the archive objections from citizens are a normal and transitory reaction to change, with homecare providers potentially lacking openness to change. Local authority champions can work in coaching internal and external professionals; workshops and training will provide adequate knowledge and skills; staff can draw on (new) persuasive skills to make sure citizens are appropriately reassured and fully informed; and homecare services can be aligned through adequate incentivising. As Symonds-Brown and Ceci (2022) note in relation to their ethnography of community day programmes for people living with dementia, 'of particular concern is how some versions of a day programme are easily displaced by the interests of administrative versions and managerial logics' (p. 1).

Across the archive, rendering potential issues to the implementation of SHC as a problem of process radically simplifies the potential messiness in the day-to-day practical enactment of SHC in such contexts as citizens' homes and conversations with family, local authority offices and telephone calls between homecare workers and their managers. It has the potential to create

artificial expectations that any and all problems and solutions can and should be managed in and through a more refined approach to 'change management'. In this archive, the type of syncretism expressed leads to a focus on managing skills, knowledge and attitude, on (individualised) behaviour change of citizens, family, local authority staff and homecare workers. Different versions of implementing SHC, such as those around acceptable workforce pay and conditions for local authority staff and homecare workers, orders of professional expertise and the constraints of technological-based solutions and the different modes of enacting the marketisation of homecare provisions are absent in this form of syncretism.

We have seen in the archive that at moments the normative puzzle cannot be solved, where this form of syncretism does not hold. Here, the absented but necessary elements to the functioning of SHC emerge from their status as temporary aberration to a version of SHC that cannot be made to fit with the hegemonic syncretic story of change management, and there is no apparent appropriate alternative for rendering a coherence of non-coherent normativity. Yet if projects like SHC are to be enacted, local authorities must not only negotiate the rendering of SHC according to multiple and sometimes conflicting duties, but this negotiation requires making present a necessary non-coherence at the same time, too messy and uncomfortable for a syncretism based on change management. It is in this sense that local authorities must be adept at undertaking normative puzzles, of rendering a form of syncretism capable of containing a coherence of non-coherence, of the subtle art of making things fit and not fit at the same time.

AUTHOR CONTRIBUTIONS

Leigh Rooney: Conceptualization (Lead); Data curation (Lead); Formal analysis (Equal); Investigation (Lead); Methodology (Equal); Project administration (Lead); Writing – original draft (Lead). **Tim Rapley**: Conceptualization (Supporting); Formal analysis (Equal); Funding acquisition (Supporting); Methodology (Equal); Writing – original draft (Supporting). **Phillip J. Whitehead**: Conceptualization (Supporting); Formal analysis (Equal); Funding acquisition (Lead); Methodology (Equal); Writing – original draft (Supporting).

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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