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‘Mum feels that the decision has already been made’: From shared decision-making to negotiated compromise in Adult Social Care

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Abstract

Adult social care policies in England promise people choice and control over their care and support, often via a process of shared decision-making (SDM). An adult social care initiative – ‘single-handed care’ – involves care provided by two workers changing to a single worker using advanced equipment and techniques. We carried out interviews with key stakeholders (n=26) involved in single-handed care. This included people providing (homecare workers), assessing for (occupational therapists and social workers), and receiving single-handed care as well as family members. Interviews were transcribed verbatim and analysed using standard qualitative processes and thematic analysis. We identified that the people receiving the service, family members and homecare workers sometimes felt that the decision to move to single-handed care had been made by the assessors before the SDM process began. The successful organisation of single-handed care required SDM to be balanced with competing responsibilities towards professional authority and accountability, and fiscal responsibility. Where there was a disagreement between stakeholders about a move to single-handed care tensions between these three responsibilities emerged. We argue that social care policies and procedures need to be more explicit about the extent to which decisions can be shared and that there may need to be a process of ‘negotiated compromise’ which sometimes allows other responsibilities to prevail.

Keywords: Shared decision-making; person-centred care; social care; single-handed care

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1. Introduction

Globally, health and social care systems are facing unprecedented demand. An increase in life expectancy has not been matched with an increase in healthy life expectancy. In the UK, health and social care service requirements are increasing with age and expenditure on social care is falling (Storey, 2018). The number of people requiring access to statutory services is outstripping both the funding and the workforce available to provide them. In England, social care has been singled out for particular focus; responsibility is devolved to regional local authorities with variation between local councils who interface with a myriad of independent service providers, alongside individuals facing uncertainty and unpredictable costs in paying for their care. Successive governments have therefore pledged commitment to ‘fix social care’ (BMA, 2022) with the current UK Government announcing, in early 2025, the formation of an independent commission to make recommendations about long-term social care reform (Samuel, 2025).

In 2021, a white paper produced by the previous UK Government - *People at the Heart of Care* - set out a 10-year vision for adult social care aiming to limit the care costs people will pay over their lifetime (Department of Health and Social Care, 2021). It stated that

> [p]erson-centred care is a key theme running through this vision. Genuine choice and control about personalised care and support can enhance quality of life and promote independence in a way that matters to individuals (ibid.: 7)

This built upon the principles of The Care Act 2014 which tasked local authorities with delivering services that promoted independence and were delivered in a ‘person-centred’ way that also promoted choice and control for the person using the service. However, the wider context of austerity meant that these services also had to be delivered against a backdrop of fiscal prudence.

The concept of Person-Centred Care (PCC) has been widely and broadly applied across medicine, health and social care services. Despite its widespread adoption, there is no universally accepted definition of it (The Health Foundation, 2106; Corbett, 2024). Pilnick (2022) has argued that there is a lack of evidence for PCC having led to tangible improvements in health outcomes and that attempts to enact it often lead to the side-lining of the expertise of health professionals and resulting in the person receiving care feeling abandoned. Similarly, Mol (2008) has contrasted the ‘logic of choice’ with the ‘logic of the care’ arguing the treatment of a care recipient as a ‘customer’ with unrestricted choices does not necessarily hold in relation to a person’s healthcare decisions.

In an overview of reviews on PCC, Sharma et al. (2015) noted that a core component was the sharing of power and responsibility between the practitioner and the person using the service. This idea, or ideal, is also consistent with the concept of Shared-Decision-Making (SDM), which is often linked to the enactment of person-centred care. For example, the UK National Institute for Health and Care Excellence (NICE) (2021) has issued guidelines for healthcare practitioners which define SDM as ‘a collaborative process that involves a person and their healthcare professional working together to reach a joint decision about care’ (pg, 5). The concept of SDM has not been widely examined in social care services and although there are some international examples (e.g. Nykänen et al., 2023; Levin et al., 2017), despite the policy drivers, to our knowledge the concept of SDM has not been widely examined within social care services in England. Indeed, the NICE guidance states that it ‘may be relevant’ for social care practitioners and people using social care services.

Nykänen et al. (2023) have suggested that SDM has a strong ‘ideological fit’ with the core values of social care professionals. However, they argue that the ‘organisational fit’ is somewhat more challenging as decisions taken in social care practice are often distributed across time, people, and different levels of social care organisation. They also highlight two differing perspectives SDM as either a ‘particular method’ or an ‘overall approach’. They highlight how it often falls between the two of these considering it an overall approach means it can be dismissed as something ‘we already do’ and where it is considered a particular method it is not always faithfully reenacted. Nykänen et al. (2023) also highlight examples from the literature where SDM has been shown to involve staff trying to persuade people to pursue a particular course of action (e.g. Land at al., 2017; Woodhouse et al., 2017).

In this paper, we examine the implementation of ‘single-handed care’ (SHC) and consider this in relation to SDM. SHC is an initiative that has become popular within UK local authorities who assess for and commission adult social care services. SHC seeks to reduce all or part of a homecare package that involves two care workers – ‘double-handed care’ (DHC) – to a single worker. DHC packages are indicated when a person requires a high level of assistance to move, such as from a bed to a chair, and when particular pieces of moving and handling equipment, such as a mobile hoist, are used. Traditionally, certain types of equipment have been deemed to require two care workers in order to maximise the safety of the person receiving care and the workers delivering it (Phillips et al., 2014). In SHC, these DHC packages are reviewed to determine if more advanced moving and handling equipment and/or associated techniques can be deployed so that the care can be delivered as safely by a single worker. Initially, the equipment and techniques are usually provided under the direction of a local authority occupational therapist who will carry out an assessment and negotiation with the person receiving the care. As the ongoing care is provided by homecare workers, commonly employed by private homecare agencies, they are also involved in the discussions about how care will be provided. A social worker (or social work team member) may be involved to ‘commission’ or set up the care package and may be involved in the negotiation around the reduction of care from two to one workers.

Literature on SHC is sparse. An analysis of local authority documents in England suggested that SHC enactment requires local authorities to manage three different, often conflicting, duties of care: to support the wellbeing of individual citizens; to maximise the common good for all through the provision of more (cost) effective services; and to deliver innovation (Rooney et al., 2023). A survey of local authorities with social care responsibilities in England identified that over 12,000 reviews of double-handed care packages were completed by 53 authorities that returned figures (Whitehead et al., 2022). All the local authorities planned to maintain or increase the number of reviews they completed and 44% had a dedicated SHC project. Both the survey and work by Harison (2017), outline some tensions between the local authorities and the homecare agencies when delivering SHC.

This paper explores how SHC is implemented in practice from the perspective of the key stakeholders involved, considered explicitly in the context of previous critical perspectives on the enactment of PCC and SDM. This includes the person receiving care, their family members, the providers of the care (homecare workers) and those who assess for and set-up the care (occupational therapists and social workers). To meet this aim, we carried out in-depth interviews with people receiving care, their family members, occupational therapists, social workers, and homecare workers with experience of SHC.

2. Methods

2.1 Study design, setting and sample

This paper is based on data collected between November 2020 and April 2022, as part of a larger study on local authority reviews of double-handed care and single-handed care schemes in England. A ‘working group’ comprised of local authority reviewing staff (social workers and occupational therapists), a homecare agency senior worker, homecare worker and family member guided the larger study. The working group contributed to the design of the study material and to the analysis and interpretation of the data in this study. Ethical approval was granted from a Health Research Authority Research Ethics Committee authorised to review research within social care (HRA Ref:

19/WM/0224). The study initially took place within two local authorities with adult social care responsibilities in England. Permissions were obtained from the collaborating local authorities.

We employed qualitative interviews over the telephone (due to COVID restrictions). Eligible participants were people who had received a review of their double-handed care package, their family members, occupational therapists, social workers and homecare workers with experiences of SHC or of moving between DHC and SHC. We used a combination of purposive and convenience sampling and initially recruited participants through two local authorities, purposively seeking participants with a range of experiences of single-handed care involvement as local authority reviewing staff, homecare workers, recipients of care (citizens) or family members. We aimed to recruit up to 15 participants from each group (local authority reviewing staff, homecare workers, citizens and family members). Local collaborators introduced the study to local authority staff and invited them to make contact with the research team. For people using the service and their families, local collaborators sought ‘consent to contact’ for the researcher to make contact with the potential participant. Due to difficulties recruiting sufficient participants within the timescales, we then expanded our recruitment strategy to include other local authorities with social care responsibilities in England, carer and homecare worker networks and organisations, and social media. Our final sample therefore includes stakeholders from different local authorities in England. Prior to conducting the interviews potential participants received a Participant Information Sheet and a discussion about the study with a researcher. Those who agreed to participate provided audio-recorded consent and agreed to have the interviews audio-recorded. Participants capacity to consent was determined using the standard two-stage capacity test by the researcher and no issues related to mental capacity were identified.

2.2. Data Collection and Analysis Procedure

Interview guides were developed over multiple team meetings which included the authors who comprised people with academic, practice, academic-practice, and lived experiences; we also consulted with the working group on key aspects of the analysis. All interviews were conducted by the same member of the research team (LR) who is an experienced qualitative methodologist and interviewer; he does not have a background in health or social care or, at the time of the interviews, detailed knowledge of single-handed care. Interviews were audio-recorded, transcribed verbatim by a professional transcription company and edited to ensure respondents anonymity.

In total, 26 interviews were completed (average 56 minutes). Nine were with local authority staff with responsibility for completing reviews of double handed care packages and / or assessing for or commissioning SHC, of these six were occupational therapists and three were social workers or social work team members. Thirteen interviewees were homecare workers. Two interviewees were people receiving care, and two were family members of people receiving care (not the same as those we interviewed). For people receiving care, we use the term ‘citizen’ to describe them as they were citizens of the local authority area in which the care was provided. We found it difficult to identify citizens and family members for interview, despite working with two local authorities and opening up a number of other avenues including other local authorities and social media for recruitment of these groups.

All analysis was conducted according to the standard procedures of rigorous qualitative analysis (Rapley, 2021). We used procedures from thematic analysis (Braun & Clarke, 2021). Sampling, data collection and analysis occurred concurrently, so that issues raised in earlier phases were explored subsequently. Coding was inductive. Some team members read and formally coded whole transcripts, others read and formally coded smaller sections. Members of the research team regularly met and discussed issues such as experience of interviews, whole transcripts, sections of transcripts, emerging ideas, formal and informal codes and coding practices. Formal codes (via Nvivo, Word), notes, formal and informal memos were produced. Over time, codes, coding and concepts were discussed, reviewed, grouped, adapted and refined. Our interpretative approach was broadly informed by relational-approaches, including Actor Network Theory that encourage phenomenon like SDM to be viewed as a contested and ongoing process of assembling relations between a range of other things, including between people, equipment, organisations, procedures, the physical environment, and, crucially, responsibilities.

3. Findings

Prior to presenting our finding, we present a vignette outlining a ‘typical’ single-handed care review and the roles of the key actors in the process, Box 1. This vignette has been primarily designed based on the experiences of the occupational therapists who were part of the research team to convey to the reader what might be considered a ‘typical’ situation (and it is not wholly derived from the data we collected for the study). It is not intended to convey whether SDM does or does not work.*Insert Box 1 here*

In our analysis we identified that, sometimes, where there was a disagreement between the stakeholders about the recommendation to move from double to single-handed care it might appear to the stakeholders not employed by the local authority (people using the service, their families, homecare workers) as though the decision had already been made. We identified that the local authority stakeholders, those carrying out the assessment for and setting up the homecare package, had to balance three competing priorities. First, that of shared decision-making; this includes placing the person at the 'heart of care' and incorporating the views of all the parties into the decision. Second, that of professional authority and accountability with the occupational therapists taking overall responsibility for the assessment of risk and the social worker taking responsibility for the funding allocated to the homecare package. Third, that of fiscal responsibility with the financial prudence of local authorities being evident in day-to-day practices. In the succeeding sections, we will show that where these priorities come together in the SHC process, they highlight certain incompatibilities which uneasily coexist. In doing so, we problematise how professional authority and fiscal responsibility can be integrated with SDM more widely for adult social care, and how we might better facilitate the functioning of care. We have categorised the data into four sections to develop our conceptual points.

3.1 *A Priori*, unilateral, decision-making

Prior to any formal decision-making to retain two homecare workers or reduce a homecare package from two to one worker, reviews of double-handed care packages usually involve one or more meetings between the key actors involved. These events generally involve representatives from three key groups: those who assess for and / or set-up the care, and who assume overall responsibility for the care cost, that is occupational therapists, social workers and/or other social work team members; the person receiving care, alongside members of their families and/or others who provide unpaid care or support; as well as the homecare providers, this might be a homecare worker or workers involved in the day-to-day provision of care to that specific person who is having a review, or a person with a more senior role within the homecare agency such as a manager or senior worker.

It can appear, for some, that the decision has been made before these meetings take place. As one family member highlighted:

> Mum feels that the decision has already been made and her opinions aren't being considered or aren't been given as much weight as they should be given. I think also she feels that she should be given the choice to make a decision that isn't necessarily the recommended one, if that makes sense? (P18, family member)

Here, in contrast to the broader national policy (Department of Health and Social Care, 2021) about placing 'people at the heart of care' and local authority documents that highlight personalisation and dignity (Rooney et al., 2023), we are given a different narrative. In this, the person receiving care, in this case as reported by her daughter, ‘feels’ that the decision is unilateral, that it ‘has already been made’. Notably, also, her mother’s ‘opinions’ are not fully ‘considered’ and other, alternate, potential choices seem absent. In this way, possibilities of choice and control appear to have been removed from the review through a process or *a priori*, unilateral, decision-making.

Such a position is not confined to people using the services or their families, with similar suggestions being made by homecare workers. When discussing the meetings to determine care arrangements, a senior homecare worker reported that:

> I think they act like within the meetings, but I think behind the scenes someone, I think someone, obviously has an overall say and usually it is kind of social workers, council, that’s what we gauge from them, that obviously we can have our input, which is fine and we have a discussion about that client, but obviously someone at the end of the day has got to have an overall say. And usually they say, “are you happy with this?” But obviously if we are not, we’re not, especially if we’re talking about, in the future, reductions from a two to one, I feel like obviously, someone has made that decision prior to us even having the meeting. (P14, Homecare worker)

The senior homecare worker’s narrative renders the meeting process of gathering views and opinions, the process of sharing and discovery, as somewhat akin to a performance. Again, the decision is reported to have been taken ‘behind the scenes’, in advance, prior to the meeting, by some relatively abstract other. In this way, the review meeting is rendered as rhetorical, more of an information delivery exercise with a usual request for confirmation - “are you happy with this?” – and even when they disagree, the unilateral decision holds, so the homecare workers have little choice or control available to them.

In situations where there is some disagreement on the final review decision participants provide similar narratives, as in the examples above, outlining a breakdown in the very idea of a more person-centred process. When disagreement emerges, choice and control are positioned almost wholly with the assessors and commissioners of care who are perceived as holding the power to give ‘the choice to make a decision’ or simply seek confirmation “are you happy with this?”? In contrast, when all parties are aligned about the same course of action, we see a different narrative, where the very same process is described as one that moves forward without resistance as in the vignette above. This is important to the assessors and commissioners of the care as one occupational therapist described: *“we want everyone really to be onboard and in agreement with the outcome because when we aren’t there it’s the carers and the family who are going through that process day in, day out”* (P5, occupational therapist). Irrespective of the (final) judgement of the process – as pretence or empowering – a series of dialogues with all the actors is positioned as core to the process.

3.2. Shared space for decision-making

Local authority occupational therapists are often tasked with taking the lead in the assessment and review process (Whitehead et al., 2022). An occupational therapist emphasised that when conducting a single-handed care review it is important to *"really listen to what they* [citizens and families] *would want and what their thoughts are"*, and she further states that *"you need to know everything before you start wading in with equipment"* (P4, occupational therapist). Here, listening – or 'really' listening – is the core. Such listening is tied to a need to 'know everything', the range of the possible and the 'want[s]' and 'thoughts' of citizens and their families prior to any further actions. Another occupational therapist echoes elements of this process:

> We are in the presence of the carer, in the presence of her mum to say, you know, "this is where we are" so everybody is speaking in one room. (P9, Occupational therapist)

We see two figures – the citizen and family member, in this case mum and daughter – as rendered as central actors in the process. The 'everybody …' can and should also include homecare workers and potentially other social care staff alongside the occupational therapist. And 'everybody … speaking' appeals to the democratic values and ideals which are evident in the wider policies that underpin social care practice in that all voices – particularly those of the person using the service and their family – are valued.

We also see a focus on a shared space here – that the 'presence' of the citizen and family member is specifically marked; this is reinforced as all stakeholders are involved in 'speaking in one room'. A shared space, be it through physical (co)presence, as well as in more metaphorical terms, is viewed by the occupational therapists as important for reaching consensus on issues. One occupational therapist explained how this was particularly difficult during the COVID-19 pandemic and that consensus was most easily achieved when stakeholders could get together in this way, in the physical same space. Bringing the various stakeholders together for face-to-face discussion is the preferred mechanism to resolve any disagreement. It was rendered as a core way in which to help 'manage' any 'resistance' that may exist when wants and thoughts differ between parties. However, creating agreement is not always, in practice, possible to achieve. In this way 'really listening' may create a space in which stakeholders share alternate 'thoughts' about "this is where we are" or where they ‘want’ to be in relation to the amount of care that is required – be it single- or double-handed – in order to meet the needs of the person receiving care. Centrally, as we show in the next section, at times participants feel that not all positions on “this is where we are” are seen as holding equivalent weight.

3.3 Professional authority and accountability

A core part of the review process is an assessment focused on identifying and evaluating the potential risks of the specific activities – moving with two or one care workers – and the associated mitigations and controls. All the stakeholders, including the occupational therapists themselves, refer to the occupational therapists’ expertise in this element of the process. A citizen reported that she valued the expertise of the occupational therapist involved in ‘witnessing’ her use of the new equipment as part of the assessment process in relation to the way in which the care was provided. A family member noted how:

> The OT [occupational therapist] is the professional, is qualified in the use of all the equipment… it’s her role to do risk assessment. So, we trusted her assessment basically. (P18, Family member)

In this way, trust in the assessment process is marked as embedded in the alignment between the task and the expertise. The occupational therapist is ‘the professional’, uniquely ‘qualified’, in just that type of assessment work. Occupational therapists told us that having a role in the SHC process fits with their ‘core skills’ and that leading the SHC assessment and review process is ‘relevant’ to their ‘professional identity’. In particular, they refer to their expertise in assessing the biomechanics of the transfer – the process in which a person moves, or is assisted to move, from one place to another such as from a bed to a chair – and their skills in analysing the activities required to carry this out.

Occupational therapists are almost always involved in the single-handed care process (Whitehead et al., 2022) and their recommendations carry considerable epistemic value for citizens, family members and other local authority actors. The strength of this (professional) authority around moving and handling is made very clear by a social worker: *“if I’ve got a recommendation of an OT* [occupational therapist] *saying someone needs two carers, then that’s it*[…] *nobody is going to dispute that”* (P3, Social worker). The local authority has a statutory responsibility to assess a citizen’s care needs and the local authority occupational therapists undertakes the assessment on behalf of the local authority. As such, when social workers need to provide evidence to support the justification for spending on a specific care package, the occupational therapist's recommendation is rendered as the authoritative position, beyond 'dispute'.

Where all parties align – where the citizen, family, local authority and homecare workers and homecare agencies agree that a specific course of action, such as double handed care is still needed – the process of 'speaking in one room', can lead to all parties feeling that (something like) 'genuine choice and control' (DHSC 2021) has been enacted. However, when a recommendation from a 'qualified' and 'trusted' 'professional' the status of which 'nobody is going to dispute' does not align with another party's opinion or judgment, the idea(l) of person-centred care cannot hold together as well. For example, homecare workers often felt that their expertise was not appropriately acknowledged:

> Our views weren't the ones that were being counted strongly enough [in a particular review]. Where with all… with no disrespect to anybody, we are there with the clients all the time. So therefore we should be taken notice of. But I think where the higher authorities are involved, there is other factors being taken into consideration. That overrules what we say at times. (P16, homecare worker)

The homecare workers repeatedly outlined how they know their clients, that they work with the citizens over time, and that they 'are there with the clients all the time'. In contrast, the local authority occupational therapists are often noted as engaging in one or two, relatively brief, (assessment) visits, as one occupational therapist reported: *"I am very aware that as a therapist you are only seeing a snapshot of somebody's life"* (P1, occupational therapist). Homecare workers' epistemic authority is, in contrast to this, embedded in a longitudinal – day by day, week by week, month by month – 'being there' assessment of the (often shifting and emergent) capacities and capabilities of the citizens they work with. As one homecare worker reported *"[Y]ou can say all these things but you can't judge care in a day… this is a good day… come back tomorrow when he struggles"* (P15, homecare worker)**.** Here, the homecare worker clearly outlines a more tacit and nuanced understanding of the people they care for, their capabilities and their variabilities. Yet, despite their unique standpoint, their views where not 'counted strongly enough'. Over time they have learnt that what they 'say at times' is overruled, despite both their expertise and their knowledge gained over time with the person.

3.4. Everyday Accounting Work

Throughout, where there is some lack of alignment, we see the participants' attempt to make sense of the problem that their perspective does not appear to have been adequately accounted for. Citizens' 'choice' and homecare workers' 'input' about risk can appear secondary to the professional risk assessment of occupational therapists. Citizens, families and homecare workers routinely outlined that 'other factors' were accountable for their (lay and professional) wants and thoughts being under-engaged and undervalued despite being so actively encouraged and explored. Notably, for many, decision making was driven by abstract and anonymous actors and/or processes somewhat outwith those they were working with – the 'council', 'higher authorities', 'professional[s]' – and was embedded in the broader context, often tied to issues around costs and cost saving for local authorities. In discussions with local authority staff, the context of cost, is also clearly marked:

> I think the pressure that is put on… having to justify… dot the 'i's' and cross the 't's' in terms of every penny that's spent. We have to, like, kind of evidence that really… A lot of challenge that we have in terms of justification, in terms of why we need that amount of cost to that care package… you feel like the manager is spending their own money. (P19, Social worker)

Local authority staff were very explicit about working in a context where fiscal responsibilities are core to their everyday practice, a constant 'pressure' they work with. Another social work team member described how this became increasingly evident since the financial crisis of 2008 and that 'everything changed' since then. In this way, people who assess and commission care have to work closely and effectively to 'evidence' specific courses of action, to justify just that cost over another in a specific configuration of a care package for each citizen.

However, local authority practitioners also stressed that working in a context of fiscal prudence does not mean that they are somehow overly led or constrained in their decision-making practices. As the social worker, quoted above, went on to note,

> We are kind of very much for the person and kind of like to have them battles with management to say, "it shouldn't necessarily be all about funding. It's the about the person's needs" (P19, Social worker).

They routinely outlined that, for them, good professional practice, is centred on always upholding the clients' best interests, focusing on and arguing for just that 'person's needs'. As one social work team member said, *"it's really about the [person] and what they need"* (P3, social work team member). All of the stakeholders highlighted how they are there for 'the person', or as a homecare worker put it *“[W]e’re there for them”* (P11, homecare worker). The practice of single-handed care is an example in which cost-savings are particularly evident in the decision making process and the tension between a focus on the person and the focus on financial resources is also rendered as intimately tied to all accounts of all the actors’ motives. The social workers and occupational therapists are, in moments, cast by the other stakeholders as acting on behalf of the budget-conscious local authority in trying to save money on care costs, through a move from two to one homecare workers. Homecare agencies are sometimes cast by the social workers and occupational therapists as trying to gain additional business in the form of more homecare hours by needing two care workers. Citizens receiving services (and their families) are, in moments, cast as trying to gain more care – two care workers – than they actually need and are thus not entitled to. In the single-handed care example, the ‘decision’ about care is therefore inextricably tied to the resources required to provide that care. This can be, and indeed is, used to raise additional doubts about the motivations of other stakeholders who are contributing to the shared decision when there is disagreement amongst the actors.

Discussion

Our findings reveal that in implementing single-handed care in social care services in England we see a process of negotiated compromise. This process emerges from the tensions that arise when trying to enact the overarching principles of ‘genuine choice and control’ within the Shared Decision-Making process in social care contexts alongside other competing responsibilities of social care providers. Our findings illustrate that choice, for the person receiving care, must necessarily compete with other factors and suggest that shared decision-making might occur within limits, but outside of those limits it can be curtailed by professional and economic considerations. In our data, an explicit focus on the (literal or metaphorical) shared space for decision-making gives an appearance of an open forum, and when all parties are aligned it can appear that a shared decision has been reached within this forum; however, where there are underlying differences between stakeholders then these can explode back out again. ‘On the ground’, and in policy documents (e.g. Rooney et al., 2023), these different responsibilities are often kept apart, where possible (cf. Law, 2002; Mol 2002). However, rather than trying to hold these separate spaces apart we suggest there is a need for greater openness and acceptance that they are all central to the decision-making process. Thus, we advocate for active recognition of their co-existence and consideration of what happens when they come together.

A key aspect of social care delivery in the UK is that organisations that provide care services (such as homecare agencies and care homes) are usually business organisations that are separate from the organisations that assess for and commission care (usually local authority councils). Thus, shared decisions involving care provision (in people's own homes, care homes, or day centres) also involves the providers of care as another party to the shared decision. The involvement of care providers in decisions that are the subject of SDM in social care adds additional rarely explored dimensions. First, in addition to the 'experiential' knowledge of the person receiving care that is central to the SDM process (Nykänen et al., 2023), we also have the homecare workers. In our data we saw that all parties recognised that homecare workers have their own 'experiential' knowledge of the care process and the citizens they work with which is often contrasted with the 'professional' knowledge of the assessors of care gained via a more 'snap-shot' process. Note here how that the professional expertise of care workers and the status of paid care work as a profession are often downplayed.

Second, the private market component of care provision renders the consideration of 'cost' more explicitly as a key aspect of the decision. We suggest that cost – which is always ever present in both health and social care decision-making – is not considered sufficiently and is often absent from much global academic literature. To our knowledge, examples which also explicitly incorporate fiscal responsibility and costs are rare with notable examples including work on decision making in fertility treatment (Hiadzi and Woodward, 2019; Bluth, 2023) and dental care (Exley et al., 2012). Conceptually, we argue, that we should not treat the citizen as a consumer in any narrow sense but rather more explicitly in that resources and costs are a central part of consumer identity and the person's identity beyond their interactions with 'public services'. As Mol (2008) has argued, the 'logic of care' extends beyond 'the logic of choice' in which the person makes decisions about their (health)care in isolation.

Our work has important parallels with previous work in this area, including some key differences. Guidelines on shared decision-making suggest that the process should involve the person receiving care and the people involved in delivering that care working together – jointly – to reach a decision (NICE, 2021). This jointness might be assumed to have occurred simply by 'the shared space for decision-making' but the joint nature of the decision can still be challenging to enact. Other studies have highlighted examples where, in the SDM process, health professionals have appeared to attempt to persuade people to take a particular course of action. For example, in a systematic review, Land et al. (2017) identified eight studies in which, when the person receiving care resisted the recommended treatment, professionals continued to pursue their commitment to their recommended course of action. Conversely, others, such as Pilnick (2022), have argued that the tension between patient choice and practitioner integrity, when enacting PCC in healthcare, can lead to ‘abandonment’. That is, the practitioner seeks to avoid persuading the person receiving care from pursuing any particular option, leaving the person feeling ‘abandoned’ and left to make the decision in the absence of advice (see also Quill and Brody, 1996). In our data, we see the opposite of abandonment. Where there is disagreement or resistance about the move from double to single-handed care we often see the local authority assessors doubling down on the decision, perhaps via what Land et al. (2017) describe as ‘pursuing agreement by changing course’ (pg. 1244). This might take the form of a new assessment by a different professional or, if that doesn’t resolve the differences, reverting back to a fiscal argument such as the person paying for the additional care costs themselves.

Nykänen et al. (2023) have previously argued that policymakers need to decide which decisions SDM (in social care) should be applied to and, further, that confusion in the overarching policies is also likely to be reflected in practice. In our findings, we see evidence of these policy-practice confusions as revealed by the practitioners’ preparedness to ‘really listen’ to what people using services and their families want, contrasted with them being wedded to the ‘professional’ authority of the assessment completed by a ‘qualified’ person. So, is it actually possible to create an SDM binary and specify which decisions SDM should apply to (i.e. those where only ‘true’ choice exists)? Or, moreover, should SDM always be viewed as part of a continuum in which choice can play a greater or lesser role depending upon the constraints it encounters when other key factors come into play? We argue, here, for the latter. Land et al. (2017) argued that, in instances where the person’s choice of outcome is not agreed by the professional, the ‘spirit’ of SDM may still be respected by working to enhance the person’s understanding of the rationale for the decision. However, this is still premised on a post-hoc explanation of the wider constraints that impacted the decision. And that the decision was never shared fully, but at best was limited and constrained, and at worst, the choice for the person was absent. So, rather than entering into a ‘shared-space’ for decision-making and introducing constraining factors only in the face of emerging differences, we suggest that SDM needs to be respecified with greater emphasis and transparency on the limits and constraints at the outset.

A particular strength of this study is the multidisciplinary team approach to the data analysis, which involved people with a range of specialisms and backgrounds. The researcher who completed the interviews, and did the primary coding, had no background or prior experience of single-handed care prior to working on this study. They brought their initial interpretations of the data to the wider multidisciplinary team including people with practice and service user experiences. Thus, as a team, we engaged in a process of continued reflexivity throughout the analysis where we became aware of and reflected on our particular perspectives. An additional strength is that, we believe, this is one of the first studies to examine single-handed care in this context and that we have included all the key actors in the process in our sample. Whilst we initially recruited participants from two local authorities we expanded our recruitment strategy, and we particularly recruited homecare workers from a range of geographical locations. There are, however, some limitations. As this was an interview study, we required the participants to retrospectively recall their experiences of the phenomenon of single-handed care and this is a limitation of all interview studies – people may have difficulties with the accuracy of their recall and may recall aspects of the phenomenon which are particularly 'storyable' rather than those that appear more mundane. Indeed, we believe that for some citizens and family members they did not want to take part where they did not consider their change from two to one care workers to be 'storyable' and is one of the reasons we have a low number of citizen interviewees; this is somewhat anecdotal based on the discussions between those approaching people for recruitment and the research team during the study.

Conclusion

Our analysis of the implementation of single-handed care has offered a perspicuous example that has revealed factors affecting the SDM process that are also likely at play in other contexts. Such factors are rarely acknowledged and / or are explicitly black-boxed. We argue that it is important for those with responsibility and involvement in the SDM process in social care to make 'negotiated compromise' more visible;and that this visibility should bridge both the overarching policies and the everyday enactment of SDM. Having 'genuine choice and control,' as outlined in the previous UK Government's white paper (Department of Health and Social Care, 2021), implies that people should have a clear option to choose between two or more alternatives. However, as in the case of single-handed care, we have shown that this is not always the case. Thus, we suggest that overarching policies need to be clear about limits on SDM in particular contexts. Policy-makers and clinicians need more realistic guidelines and principles about how all stakeholders 'on the ground' need to negotiate their way around 'choice and control' – through the shared space for making decisions – whilst also balancing the other responsibilities. The competing responsibilities of professional authority and accountability, and fiscal responsibility are likely to be key across a range of other contexts.

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Shared decision-making might fail because of stakeholders' competing responsibilities

Singe-handed care in English local government provides a perspicuous example of this

Professional authority can lead to stakeholders feeling decisions are predetermined

Fiscal responsibility might overshadow the emphasis on choice and control

'Negotiated compromise' should be more visible in the shared decision-making process

Box 1- Case study Vingette

Mrs X had a homecare package in place with one carer three times per day. She was independently mobile but had a fall and was admitted to hospital. Following several weeks in hospital she was unable to weight bear to transfer independently and was discharged from hospital with an increased care package of two carers four times per day to assist her with her transfers. New equipment was put in place which included a mobile hoist and sling and the care package, on discharge, involved two care workers to provide assistance to move (transfer).

The 'double handed homecare review' began when Mrs X's social worker, who commissioned the care package for her leaving hospital, contacted her colleague, a local authority occupational therapist, to review the double handed care package and equipment with a view to possible SHC.

An initial visit is arranged with the occupational therapist, to Mrs X's home. Also present on the visit are Mrs X's daughter and two care workers. The visit is scheduled to coincide with a routine care call. The occupational therapist observes the care call and carries out an additional environmental and functional assessment with Mrs X.

All parties agree that new equipment should be put in place on a trial basis to be used with one care worker and Mrs X. It is agreed that the care package will remain at two care workers for the trial period but that the second care worker will not assist with the transfers unless necessary.

A subsequent 'review meeting' is arranged for one week later involving the occupational therapist, Mrs X, her daughter and a senior worker from the homecare agency. Feedback from Mrs X and the care workers over the trial period is that the new equipment is working well with one care worker. All parties agree that the original equipment can be removed and the care package can change to a single worker, with the new equipment.

The occupational therapist contacts the social worker to feedback and report that the care package can change. The social worker arranges for the care package to resume as 'single-handed care'.

Ethical approval was granted from a Health Research Authority Research Ethics Committee authorised to review research within social care (HRA Ref: 19/WM/0224).