The Spaces of Personalisation: Place and Distance in Caring Labour

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The cluster of reforms to English social care associated with personalisation mark a break with recent thinking about what spaces are considered relevant and appropriate for people with an assessed social care need. The promise of personalisation from a spatial perspective appears to be twofold: expanding the physical spaces that are available to people, while at the same time contracting interpersonal spaces between people and those who support them to emphasise attentiveness and particularism. However, there is a danger that personalisation is much more variable in its impacts. The physical spaces for some are expanding while for others they contract, and these opportunities are likely to be unequally distributed in ways that overlay other forms of inequality. The attentiveness and particularism promised by personalisation is again patchily distributed, with wide variation in the quality of support planning and person-centred care. For the formal care workforce, the two concepts of space (physical environment and interpersonal closeness) intersect as physical spaces shape the capacity to deliver attentive, responsive care. The article brings these concepts together through a discussion of 'caring labour' at the intersection of the physical and emotional aspects of space.

Keywords: Personalisation, personal budgets, emotional labour, social care, home care.

Introduction

The spatial aspects of care are well documented. Social geographers, interpretive policy analysts and theorists of care and embodiment have provided different perspectives on the spaces of care. Thus we know about how buildings operate as carriers of meaning (Yanow, 2000), the extent to which sets of practices are constitutive of places (Milligan, 2000, 2009; Parr, 2000; Conradson, 2003) and the ways in which interpersonal spaces are experienced and negotiated (Twigg, 2000). Spaces are recognised to be constitutive of social praxis, rather than being merely sites within which practices take place (Massey, 1984; Herod *et al.*, 2007).

Personalisation in English health and social care services is changing the spaces which people inhabit. Personalisation is, of course, a difficult label to apply without critiquing and problematising it (West, 2013). However, here discussions about its fluidity and ambiguity are bracketed off, and it is deployed to mean a policy intervention which aims to give people who use health and social care services more choice and control over how they are supported. The policy is furthest advanced in social care services for older people, adults with a disability and people using mental health services, and is most strongly associated with the devolution of budgets down to the individual or a nominated budget-holder (Needham, 2011). Outside of social care, personal health budgets have

been trialled in the NHS for people with a range of conditions such as diabetes and chronic obstructive pulmonary disorder (Department of Health, 2009). These budgets are now being rolled out nationally for people receiving continuing healthcare funding, and localities are being encouraged to offer them to people with other chronic health conditions. Budgets are also available for the parents of children with disabilities and special educational needs, and are being proposed for a range of sectors such as adoption services and rough sleepers (Hough and Rice, 2010; Needham, 2011; Department for Education, 2013). Individualised budgets are also part of the Department of Work and Pensions' Right to Control initiative, designed to make it easier for disabled people to access work (DWP, 2008).

Some of the detail of the personalisation policy comes out in the discussion below, but this article does not dwell on the complexities of definition. Taken as a policy label and set of nationally prescribed interventions, an interesting feature of personalisation is that it promises to expand the physical spaces that are available to people who need support, whilst contracting the interpersonal spaces between people and those who support them. This potential duality, expansion of the physical places which people can access and contraction of the interpersonal spaces of care, and its implications, is the focus of this article. The discussion explores how people with an assessed social care need interact with paid carers and professional care workers, who are of course only one part of the broader infrastructure of care. Personalisation has implications for unpaid carers, and these are being considered by others and are not included here (for example, Mitchell *et al.*, 2013; see also Pratesi, 2011; Rummery, 2011). The sections below look in turn at the extent to which personalisation is expanding the physical places in which people receive support and at how far it is encouraging relationships which contract the interpersonal spaces within which people plan and provide care. Physical and relational space here refer to different aspects within the heterogeneous concept of space (Massey, 2005), and therefore expansion and contraction in these aspects are not intended to be opposites. Nonetheless, the 'caring labour' that goes on at the intersection of the physical and emotional aspects of space, is a reminder that they are closely related dimensions. Milligan reaffirms this strongly in a care context: 'The interrelationship between the physical and affective aspects of caring and how this both shapes and is shaped by the social and spatial environment within which care takes place is thus important in helping us to understand how care manifests in different ways in different places' (2009: 120).

Personalisation and expansion

The places within which people experience care and support are shifting in a context of personalisation. Personal budgets are designed to be a permissive intervention which allows people to make their own choices about how and where they want to receive care and support (HM Government, 2007). This facilitates individualised commissioning of support which is more tailored to the individual. It also aims to make it easier for people to access 'universal' environments, such as leisure centres, libraries, shopping centres, cinemas, bowling alleys and parks (HM Government, 2007). This may be achieved through facilitating the employment of a personal assistant and/or making places more accessible and welcoming. There are examples of people with a disability using a budget to facilitate a family holiday to Centre Parcs or abroad, rather than assuming that respite care or another kind of bespoke setting is the only option for a break (Leadbeater *et al.*,

2008). Dementia cafes are growing in popularity, either as informal places for information and support, or more formal places for themed discussion on the Alzheimer Cafe model (Graty, 2008). Within the NHS, the personal health budget pilots have shown the scope for people to use budgets to widen the settings within which support is being given (Forder *et al.*, 2012). People can access alternative therapy centres, for example, which are not conventionally supported by the NHS (for example, for aromatherapy and massage), or attend private gyms or Weight Watcher meetings.

There are also new virtual spaces emerging for care and support. Although not a causal effect of personalisation, the co-occurrence of social media and personal budgets has fostered a linkage between the two. Social media can facilitate the pooling of budgets, so that sufficient support can be arranged to allow a group outing or shared purchasing of equipment (Stephens and Michaelson, 2013). Online portals have made it easier for people to access support and brokerage for personal budgets. Sites such as Shop4Support help people to make choices about how to spend a budget.

Personalisation then can facilitate access to a range of new places which people can utilise as groups or individuals. If this access costs money, then personal budgets enable people to withdraw from collectively funded services such as day centres and use the money as individual 'commissioners'. This clearly has consequences for the sustainability of collective services, highlighting that personalisation may be about a withdrawal of some places as well as the opening of new ones. A survey by the journal *Community Care* and the trade union Unison found that 56 per cent of social care workers agreed with the statement, 'Services such as day centres are being closed down in my area on the grounds that personal budgets will mean reduced use' (Dunning, 2010a: 15). In the current fiscal context, with local authorities making up to 25 per cent cuts in social care budgets (Dunning, 2010b), financial concerns are also prompting local authorities to close or restructure day services in favour of more personalised alternatives (Beresford *et al.*, 2011). Mencap, a charity for people with learning disabilities, used a Freedom of Information request to 151 English local authorities to report that 'almost 1 in 3 (32%) local authorities have closed day services. 1 in 5 (20%) of these did not say they have provided replacement services . . . 3 in 5 (60%) local authorities have increased charges for day service attendance and related services such as transport, on average by 70%' (Mencap, 2012).

The implications of this are highly contested (for a discussion of this see Needham, 2014). For some people, day centres are an example of a segregated, low-quality service that needed phasing out. For others, the centres are places of community, and their closure has been bitterly contested. This contestation is in part a reflection of the battle over policy framing which is evident in other aspects of welfare reforms. It also reflects the diversity of views of the users of those services (Needham, 2011). Advocates of personalisation envisage that day centres will be replaced by community hubs, and this is happening in some areas. In Surrey, for example, they have set up a network of user-led hubs, which aim to be 'drop-in shops on local high streets for information, advice, advocacy and other services about care and support [which] . . . help people stay independent' (http://www.thesurreyhubs.org.uk/). There are examples of charities and user-led organisations taking over day centres and changing the ethos and activities, with greater focus on member participation and self-determination. 'Day clubs' in Australia are an example of such an approach (Fawcett *et al.*, 2012), and Age UK has similarly moved in such a direction with its Wellbeing centres. As statutory funding is withdrawn,

such places could offer a set of services for people with personal budgets (and indeed self-funders) to purchase.

However, the research by Mencap highlighted the extent to which the shift to personal budgets, in a context of large-scale budget cuts, is leading to people being 'Stuck at home' as the title of the report puts it (Mencap, 2012). A survey of day centre workers, in association with Unison, highlighted that many of these workers were suspicious about the motives for the shift away from centre provision. As one respondent put it, '[Personal budgets] has given management the excuse to close Day Centres despite the fact that the number of service users wanting to use them has not dropped' (cited in Needham, 2013: 7). It can be argued that personalisation, like the deinstitutionalisation narrative that accompanied the closure of long-stay hospitals, is having more success as a narrative of closure and critique than as a stimulus for the emergence of new collective spaces (Needham, 2014).

Thus the promise of spatial expansion, which is a key element of personalisation, needs to be recognised to be highly contingent and person-specific. Some critics of the current incarnation of personalisation have argued that personal budgets expand choice and control for people who are already well supported and networked, just as direct payments before them did. Advocates of personal budgets suggest that this is not a reason to abandon choice and control, but to pursue it more ardently so that the benefits are more diffused (on this see the debate between Slasberg and Hatton, 2011). Certainly, the roll out of personalisation in a context of fiscal austerity and bureaucratic complexity ensures that as local authority services are withdrawn, it can be difficult for people to access or even know about what is replacing them (Baxter and Greener, 2011; Slasberg *et al.*, 2012a, b). The 2013 National Personal Budgets (POET) survey found that although 'responses relating to impact on life were overwhelmingly (97 per cent) positive . . . people's experience of the personal budget process was mixed, with over half (60 per cent) of the responses relating to process being broadly negative' (Hatton and Waters, 2013).

Process barriers are likely to be particularly off-putting for those who lack skills of self-advocacy or do not have people to advocate for them (Slasberg and Hatton, 2011). There was wide variance across councils in the POET findings, highlighting geography as a relevant factor in explaining unequal access to the benefits of personalisation. There may also be an age-relevant distinction here, with the policy aiming to open up the spaces of care in ways which are less relevant for older people than they are for younger disabled people (Barnes, 2011). Lloyd notes the prevalence in policy documents on personalisation of the discussion of access to 'further and higher education, training to prepare for a job, employment, bringing up children, caring for other family members, volunteering, involvement in sport, leisure and social activities' (2010: 193). She suggests that this highly instrumental view of social care, as a means of restoring people to their functions, fails to reflect 'dependencies that arise from frailty and ill-health in old age' (Lloyd, 2010: 193).

Personalisation and contraction

Moving to an emotional conception of space, it is possible to argue that personalisation has implications for the professional distance and formalisation which characterised the care management era (Sowerby, 2010; Ellis, 2013). As Lloyd puts it, 'A key characteristic of the personalisation agenda in social care specifically is that an individual's interpretation

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of his/her needs and the ways in which these should be met must be at the heart of any intervention' (2010: 189). According to an Association of Directors of Adult Social Services (ADASS) document, *The Case for Tomorrow*: 'For many older people the choices they want are not so much about who provides, but what is available, when and whether they feel they have a rapport and relationship with that particular care worker' (ADASS, 2012: 51).

Particularism has long been seen as an essential element of an ethic of care (Tronto, 1993; Sevenhuijsen, 1998; Mol, 2008; Lloyd, 2010; Barnes, 2011, 2012). Barnes (2012) writes of the importance of care being 'attentive' and 'particularistic', oriented around what is appropriate for the care receiver. This is very much the animating principle of personalisation as promoted by advocates such as *In Control*, the Think Local, Act Personal consortium and the Social Care Institute for Excellence. As Lloyd puts it, 'Tronto's concept of responsiveness is at the heart of the personalisation agenda, since enabling those using services to define their needs and how these should be met is, ostensibly, what personalisation is all about' (2010: 191). This is suggestive of an attentiveness which marks a clear point of departure from some aspects of the service-led approach in English social care services in which 'the promotion of personhood' was underdeveloped (Fawcett *et al.*, 2012), although the 'ostensibly' in Lloyd's quote must not be ignored and is returned to below. For people delivering care, or working on a support plan, personalisation then requires a repertoire of skills that include listening, relating and emoting (Carr and Dittrich, 2008). As expressed by its advocates, personalisation offers the potential for care to be what Yeatman calls 'an inter-subjective relationship between selves' (2009: 18).

Yeatman argues that welfare services in market economies do not foster sensitivity to the self in this way, instead designing services so that 'the service client is repositioned as a consumer whose will is to be served by the professional/service worker' (ibid.: 93). Such claims reprise the citizen-consumer debates which have been live within public services for several years, and are particularly pertinent to personalisation (see, for example, Clarke *et al.*, 2007; Ferguson, 2007; Needham, 2007; Scourfield, 2007). Claims of a consumerisation of care are very plausible, particularly given the system-level commodification which has taken place since the 1990s (Lymbery, 2012). The 'ostensibly' in Lloyd's quote is a reminder to be attentive to the differences between the promise of personalisation and the practice of social care reform. Houston, for example, develops a critique of personalisation which highlights an individualistic rather than relational account: 'at the heart of [personalisation] is an impoverished ontology, namely one that fails to accord sufficient weight to the primordial and existential realities of human inter-dependence, inter-being and symbolic interaction' (2010: 842).

However, it is possible to argue that the experience of personal budget implementation in a series of sectors has shown the potential for a more relational foundation than Houston allows. The Department of Health-funded evaluations of personal budgets (Glendinning *et al.*, 2008) and personal health budgets (Forder *et al.*, 2012), along with a Joseph Rowntree Foundation evaluation of a rough sleepers pilot (Hough and Rice, 2010), have all suggested that the support planning process can facilitate new relationships of particularism and attentiveness. The personal budget pilot evaluation, for example, found that:

> Service users and carers frequently reported that specialist support planners had focused on the individual and offered a personal touch that built up a bond between planner and user. Others

reported that not only did their support planning lead to a successful programme of care but the process was enjoyable too: 'We made a plan together with my broker. I quite enjoyed doing it because we did it together. I did some drawings and pictures of what I wanted to do and found it very interesting'. [Service user with a learning disability] (Glendinning *et al.*, 2008: 159)

The evaluation of personal health budgets similarly identified one of the positive impacts of the budgets as being: 'Improved relations between the NHS and personal health budgets holders as views are being listened to' (Jones *et al.*, 2010: 15). According to one of the health professionals interviewed:

The major advantage is you get a kind of personable energy with people [budget holders], and people start to engage with you very much more on a level where they feel that they can trust you. It's a process of working through what we need to do in terms of the planning and as a bi-product you get to know the person [budget holder] much better which benefits both. [care planner and budget holder] (cited in Jones *et al.*, 2010: 8)

The Joseph Rowntree Foundation evaluation of an individual budget approach for supporting rough sleepers reported something similar. As one of those who had had a budget put it, 'I've got to be honest here, it wasn't just the individual budget, it was the fact there was [co-ordinator] there as well . . . We was meeting [regularly] to discuss it, and I'd actually gone from the stage of wanting nothing to do with these people, to actually looking forward to seeing them' (cited in Hough and Rice, 2010).

These findings, all of which are from the early stages of planning and using personal budgets, at least suggest a need for caution in claims that personalisation and personal budgets are by necessity individualising and consumerising interventions. Changes to the provision of care within a context of personalisation and personal budgets, the time spent on care planning and the increased prevalence of personal assistants, may foster the emotional attentiveness which personalisation promises. It is important to note that the quotations here are focused on the support planning phase, which precedes the delivery of support services themselves. Support planning is a highly variable practice, dependent on the skills and attitudes of planners and the extent to which their activities are funded and supported by local authorities (Williams *et al.*, 2013). Within the provision of support itself, the impact of personalisation again may be distributed according to income inequalities and geography, but there may also be an age-based pattern, with older people funded less generously by the state than younger disabled people (Lloyd, 2010).

Space and distance in caring labour

The interpersonal contraction and physical expansion, which personalisation demands, may require a more intense kind of 'caring labour' from the formal workforce than in the care management era of the recent past. 'Caring labour' is a term which Himmelweit (1999) puts forward as a subset of the broader concept of emotional labour. Emotional labour is defined as, 'the expression of one's capacity to manage personal emotions, sense others' emotions, and to respond appropriately, based on one's job' (Mastracci *et al.,* 2010: 125). Although the emotion work, which people in service sectors undertake has been written about for decades (Menzies, 1960; Hochschild, 1983; Smith, 1992; Guy *et al.,* 2008; Mastracci *et al.,* 2010), it appears to have a contemporary salience within British public services. In its response to the Francis Report into events at

Mid-Staffordshire NHS Foundation Trust, for example, the government explicitly evokes the concept of 'The Emotional Labour of Care' and writes: 'Working in health and care is inherently emotionally demanding. To support staff to act consistently with openness and compassion, teams need to be given time and space to reflect on the challenging emotional impact of health and care work' (Department of Health, 2013: 31).

As in this quote, the literature on emotional labour often deals with spatial considerations, either directly or in passing: where do workers go to restore themselves after a difficult emotional encounter? Literature on the NHS suggests that this may be a sister's office for nurses, or back to base for ambulance crews (Sawbridge and Hewison, 2011). In a care context, Tronto (2010: 169) similarly has drawn attention to the importance of spaces which are conducive to identifying and resolving ethical conflicts relating to care. As Barnes puts it, 'Having spaces and times in which [troubling or upsetting] issues can be explored and discussed is an important way in which responsibilities for care become shared beyond a specific dyadic relationship' (2012: 76).

The physical spaces in which reflection and recovery take place appear to be disappearing in a range of professions, as workplaces are streamlined in order to make services more efficient. Nurse handovers are more likely to occur at the bottom of a bed rather than in a sister's office; paramedics are more likely to spend time between calls in a layby than back at base (Sawbridge and Hewison, 2011). What Cooper and Lousada (2005) characterise as the 'vanishing organisation' within modern welfare services is increasing the exposure and anxiety of those undertaking care work. For those working in social care services, such spaces have always been underdeveloped. Barnes notes that home care in particular lacks opportunity for 'collective ethical reflection', compared to hospitals and residential care homes, given the fragmented and isolated settings in which it takes place (2012: 82).

Although the social care workforce may lack physical places of support and recovery, Himmelweit (1999) suggests that an ameliorating factor may be the emotional closeness they build up with the person they are caring for. She argues that whereas the emotional labour literature has emphasised the role of performance, in which workers 'suppress their private feelings, in order to show "desirable" work-related emotion' (Mastracci *et al.,* 2010: 125), this may be less necessary in a care setting. According to Himmelweit, 'Caring . . . specifically involves the development of a relationship, not the emotional servicing of people who remain strangers' (1999: 35). Over time, this continuing relationship should 'be all that is needed to generate the appropriate emotional ties' (1999: 35). She recognises though that such relationships will not always develop, and if they do not, 'maintaining appropriate emotional engagement may be as hard and as wearing as in the more transitory forms of emotional labour' (1999: 37).

How this plays out in practice is likely to be different for different parts of the care workforce. For social workers, personalisation is expected to facilitate new kinds of conversations, based on surfacing people's assets and aspirations rather than focusing on their deficits and care needs (Lymbery and Postle, 2010; Leece and Leece, 2011; Lymbery, 2012). Social workers may be involved in drawing up a support plan, foregrounding skills of advocacy and brokerage rather than needs assessment and rationing (Lymbery, 2010; Leece and Leece, 2011). This process has been described as a rediscovery of 'real' social work, from a lost era of community social work or the unrealised promise of 'tailor made' care in the community care reforms of the 1990s (Hudson, 2009; Lloyd, 2010: 192;

Williams and Tyson, 2010). It may facilitate the therapeutic and relational kinds of social work that users value (Sudbury, 2002; Trevithick, 2003; Beresford, 2007). However, it may also weaken links between social workers and users of care services as people choose to make more use of independent support workers and/or have limited access to dwindling numbers of qualified social workers (Scourfield, 2010; Leece and Leece, 2011; Lymbery, 2012). As Lymbery puts it, writing about personalisation, 'The place of social work in the new policy is contested and unclear' (2012: 784).

Within a domiciliary care setting, the availability of direct payments is shifting the balance between agency care workers, who attend several people for short periods, towards personal assistants, who can focus on a one-to-one support relationship. Personal assistants have the opportunities to build up long-term relationships in the way that Himmelweit describes. Glendinning *et al.* drew on focus group discussions with personal assistants to observe that, 'Personal assistants also appreciated the emotional quality of the relationship which they developed with an employer over time' (2000: 206). However, Leece highlights the difficulties which personal assistants may experience in establishing boundaries and appropriate working practices: 'the direct employment relationships were designed by employers primarily to serve their own interests, and the friendly, family-type arrangements they created resulted in obligations that made it difficult for workers to exit the arrangement, despite the many shortcomings of their position' (2010: 202, see also Spandler, 2004; Yeandle and Steill, 2007; Leece and Peace, 2010). Glendinning *et al.* (2000) found that direct payment holders preferred to train personal assistants themselves rather than encouraging access to formal training, so that they did not become too 'professionalised'. Williams has written about the blurring of boundaries that can go on for migrant care workers, in which being treated like a 'member of the family' means being 'continually on call' (2010: 386). Contra Himmelweit, the development of a long-term relationship may not in itself generate the 'emotional ties' that distinguish caring labour from the emotional labour of the service sector.

For agency care workers, the personalisation context raises a different set of issues. It may provide a further casualisation and commodification of the care relationship (Leece and Peace, 2010). The extension of personal budgets and the growth of individualised commissioning may reduce job security for agency staff, leading to greater use of zero hour contracts as agencies try to pass on the risk of uncertain demand to their staff (Baxter *et al.*, 2011). As Mullin observes, 'Care laborers who barely have time to assist their clients with bathing will not have time to listen to and learn from their clients about how they may best meet not only their physical needs but also their need to maintain their dignity and privacy in the midst of their vulnerability' (2011: 120). Interviewing care agencies about the impact of personal budgets, Baxter *et al.* note that providers were keen to ensure that 'professional distance' between care workers and clients was maintained:

> Providers believed the caring nature of care workers sometimes meant that they overstepped the professional boundaries of relationships, for example by taking clients to their own homes. Providers were concerned that these distinctions would become blurred and there would be pressure on providers to encourage a relaxation of these boundaries if [personal budget] users came to expect caring relationships more akin to friendships. (2011: 63)

The impact of personalisation on caring labour is therefore likely to be variable across the workforce (as well as in different geographies and for people with different

levels of impairment and isolation). A shared tension for social workers, personal assistants and agency home care workers is between professionalisation and particularism. Professionalism is equated with worker expertise and discretion, and can also be suggestive of distance, reflection and self-care which can help workers to sustain and contextualise the labour of care (Davidson, 2005). As Yeatman puts it, 'if there is no support for the worker's capacity to contain the emotional aspects of service work, it is not likely that the worker will be able to sustain careful and individually-respectful as well as responsive care' (2009: 113). Yet professionalism is highly contested within a personalised welfare state (Needham, 2011; Evans, 2013). The tensions are most obvious in the rejection of professionalisation by the employers of personal assistants (Glendinning *et al.*, 2000; Leece and Leece, 2011). They are also evident in the fears that personalisation constitutes a deprofessionalisation of social work and the devaluing of social work expertise (Ferguson, 2007; Lymbery, 2012). Changes to the working practices of agency care workers, with the increased use of zero hour contracts and the further casualisation of the sector, similarly indicate a retreat from professionalisation, albeit one in which the importance of 'professional distance' is averred.

Conclusion

Personalisation interacts with the spatial in a range of ways. It opens up new spaces, whilst delegitimising and closing down others. Day centres are closing or being redesigned; community hubs are opening in some places or else more transitory, multipurpose spaces such as dementia cafes and carer cafes are emerging. Personalisation calls for and facilitates new practices within care spaces, lessening the emotional distance between people who access support and those that support them in paid roles. Attention to personhood and particularity is a recurrent theme of personalisation (at least as envisaged by its advocates within disability organisations).

This then can be characterised as the promise of personalisation from a spatial perspective: the expansion of the physical spaces which people can access and the contraction of interpersonal relationships to be more attentive and empathetic. The focus here has been on social care services, but the same spatial implications may be applicable to other public services, as hospitals and schools strive to become more person-centred. Academy schools offering personalised learning, for example, have used the Swedish Kunskapsskolan model in which pupils have much more physical freedom to choose spaces for learning, alongside a close relationship with a learning mentor (Eiken, 2011).

However, there is a danger, highlighted here in the discussion of social care, that personalisation is much more variable in its impacts. Thus the physical spaces for some will expand whereas for others they contract, and these opportunities are likely to be unequally distributed in ways that overlay other forms of inequality. The emotional closeness promised by personalisation is again likely to be variable in its impacts. Support planning may create opportunities for closer and more responsive relationships to emerge, as it has in the personal budget pilots. However, there may be difficulties in sustaining these benefits beyond well-funded pilots, particularly in the current context of major funding cuts to social care services. There are also tensions between the particularism of personalisation and the professionalism of the care workforce, which may inhibit the scope for workers to exercise self-care.

The caring labour required by personalisation needs to be located within a broader ethic of care, which is a more inclusive and normatively powerful approach than that of emotional labour. The ethic of care ranges beyond the specific interaction of care giver and receiver to the institutional and socio-political context within which care is given. As Barnes puts it, 'The relational ontology of care calls attention not only to the particular, personal needs of individuals, but also to the socio-political context in which those needs are produced and experienced, and to the processes by which difference and consequent exclusions are constructed' (2012: 31). It is the relative silence of the personalisation-oriented reform programme on such issues that has created such an ambivalent response from organisations campaigning on disability and ageing. The scope for personalised interventions to close down collective responses and identities has been one cause for concern (Spandler, 2004; Barnes, 2008; Roulstone and Morgan, 2009). Another has been the inadequacy of the funding models and market approaches that characterise personalisation, suggesting that it cannot be expressive of an ethic of care (Ungerson, 1997; Tronto, 2010; Rummery, 2011; Barnes, 2011, 2012). The massive contraction of social care spending over the past two years has led to an intensification of pressures to keep costs low and tighten eligibility criteria (Fernandez *et al.*, 2013). In the context of domiciliary care, many workers may seek to embody an ethic of care, whereas the circumstances under which they perform the work make it feel more like a performance of emotional labour. If the recent Francis Inquiry has kick-started a national debate about how to sustain nurses' capacity to care, this should be extended to a social care setting in which care is too often taken for granted.

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