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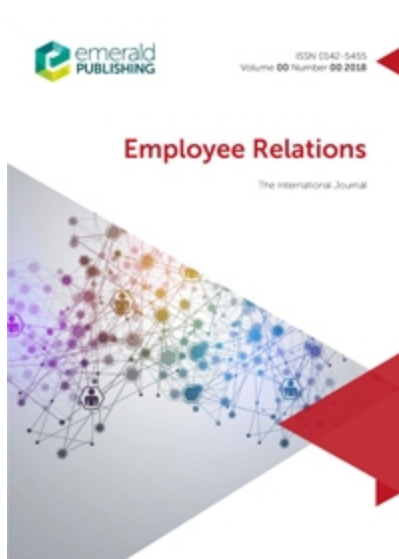
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Fragmented time and domiciliary care quality

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Fragmented time and domiciliary care quality

Abstract

Purpose: This article examines the marketization of domiciliary care, its consequences for employment practice, specifically fragmented time, and the implications for care quality.

Design/methodology: Focus groups and face-to-face or telephone interviews were conducted with care commissioners, service providers and care workers across Wales. There were 113 participants in total

Findings: these demonstrate fragmented time's negative consequences for service providers, care workers and, ultimately, care quality.

Research limitations: No care recipients were interviewed and care quality was explored through the perceptions of other stakeholders

Social implications: For policy-makers, tensions are evidenced between aspirations for high quality care and commissioning practice that mitigates against this. Current care commissioning practices need urgent review.

Originality/value: the research extends the definition of fragmented time and integrates it with a model of care quality to demonstrate its negative consequences. Links between employment practice and care quality have only previously been hinted at.

Keywords: domiciliary care, fragmented time, care quality, marketisation

Research article

Introduction

As Western populations age, so the demand for adult social care increases. Domiciliary care, one form of social care, affords personal care, protection or social support for vulnerable adults in their own homes (Gray and Birrell, 2013) and should improve quality of life for (mainly) older people (Francis and Netten, 2004). Yet high profile UK scandals have raised concerns over care quality (Kingsmill, 2014, Flynn, 2015) and, while the context here is Wales, these concerns are reflected internationally (Cunningham et al., 2014, Broadbent, 2014). Inadequacies in care provision have substantial ramifications. Directly, some of society's most vulnerable adults suffer poor care and thus poor life quality. Indirectly, effective operation of health care systems is compromised by, for example, 'bed-blocking', whereby hospital discharge is delayed due to lack of available social care provision (e.g. Marsh, 2016), to an extent that threatens to de-stabilise health care provision. Delivery of high quality social care is thus an urgent imperative.

Addressing this imperative requires an adequate and skilled workforce (Rainbird et al., 2011), which depends upon effective employment relationships. Yet recently in this journal, Rubery (2015) outlined a series of trends that adversely affect employment practice and are particularly pertinent to domiciliary care. First, fragmentation, where marketisation promoting outsourcing and use of external providers has created a move away from standard forms of employment, with social care being a particular example of resulting insecurity and zero-hours contracts (Rubery and Urwin, 2011). Second, flexibilisation of employment being demand- rather than supply-led, again with resultant workforce insecurity. Finally, feminisation of employment, which is highly relevant given the gender segregation that prevails in social care, and which facilitates insecurity (Moore and Tailby, 2015). These trends have, in combination, degraded working practices and created what Rubery et al. (2015: 753) have recently described as 'fragmented time' in which insecure and highly flexible working patterns dominate. Given that the link between employment practice and service

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3 quality in other contexts is well-established (Whyman et al., 2015), the article addresses the
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5 research question, what are the consequences of fragmented time for care quality?
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11 The article makes a valuable empirical contribution to the social care employment research base
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13 (Cooke and Bartram, 2015), importantly adding care workers' views (Cunningham, 2010) not just on
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15 their employment situation, but also on care quality. Theoretically, it both confirms Rubery et al.'s
16
17 (2015) definition of fragmented time, evidencing an employment offer predicated upon zero-hours
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19 contracts and episodic working, and extends it in adding visit length (Bee et al., 2008). Further, it
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21 integrates fragmented time with Francis and Netten's (2004) dimensions of good care to
22
23 demonstrate the detriment to quality that fragmented time brings in reducing continuity, reliability
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25 and flexibility of care. This moves beyond the thus far tentative links proposed in existing domiciliary
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27 care research (Broadbent, 2014, Cunningham, 2016) to evidence that poor employment practice
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29 compromises care quality. For policy-makers, the article demonstrates substantial tensions between
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31 policy's aspirations for high quality care and funding/commissioning practice that mitigates against
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33 good employment practice.
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39 The article proceeds by outlining the marketization of domiciliary care and the implications for social
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41 care employment relationships. It then theoretically frames fragmented time and care quality,
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43 before presenting research methods and findings/discussion. It concludes with research
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45 contributions and implications.
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51 **Marketisation and domiciliary care employment relationships**

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53 In many neoliberal economies, there has been marked reduction in state provision of domiciliary
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55 care over recent decades (Cunningham, 2008). A shift to marketised relationships has occurred in
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57 which the state, via local authorities, commissions most domiciliary care from independent (private
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59 and voluntary) sector service providers (Cunningham et al., 2014). Understanding of commissioning
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2
3 is essential to examination of both wider employment practice (Rubery et al., 2013) and, specifically,
4
5 fragmented time (Rubery et al., 2015). Marketisation draws on supposedly efficient business
6
7 principles and aims to improve care quality. In practice, the external commissioning of care has long
8
9 been associated with quality concerns, related in large part to the cost pressures that have
10
11 dominated local authority commissioner agendas (Cunningham, 2010). Indeed, Cavendish's (2013)
12
13 review of UK care failures argued that local authority monopsony of commissioning suppresses rates
14
15 and UK Home Care Association, the employers association for domiciliary care providers (UKHCA,
16
17 2015a), reports that care is often commissioned at less than its cost priceⁱ. Inadequate funding is
18
19 compounded by insecure commissioning arrangements, with a move away from block contracts,
20
21 where an agreed number of hours are purchased whether used or not, to spot contracts, where
22
23 payment is only made if care is taken up (see Knapp et al., 2001 for detailed explanation). Time is the
24
25 unit of account adopted (Rubery et al., 2015) and domiciliary care provision is typically measured in
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27 minutes with, in a drive for efficiency, the increased use of short visits of 15 and 30 minutes or less
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29 (Bessa et al., 2013). Using spot contracts, commissioners operate Framework Agreements that
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This has substantial implications for social care employment relationships (Broadbent, 2014) which, as Framework Agreements rarely address terms and conditions of employment (Burrowes, 2015), have limited protection from market pressures.

Marketisation and associated funding pressures, particularly in times of austerity, have occasioned the erosion of fulltime, permanent domiciliary care jobs (Broadbent, 2014) and, internationally, there has been a convergence of regimes based on low pay, insecure employment and work intensification (Cunningham et al., 2014, Broadbent, 2014). In the UK, poor social care employment

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3 practice is widespread in both the private (Rubery and Urwin, 2011) and voluntary sectors, where
4
5 Cunningham describes a 'race to the bottom' (2008: 1033). Green and Ayalon (2017) echo this,
6
7 arguing that domiciliary care workers are susceptible to various forms of abuse and calling for closer
8
9 scrutiny of their working conditions. While their research focuses particularly on migrant labour, the
10
11 issues are nevertheless relevant to the predominantly Welsh workforce considered here. This article
12
13 explores one important aspect of employment, fragmented time (Rubery et al., 2015), and its
14
15 implications for care quality.
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23 Fragmented Time

24 The paper builds on Rubery et al.'s (2015) argument that time is a critical issue within domiciliary
25
26 care. This flows both from commissioning practice, discussed above, that adopts time as a unit of
27
28 account and the use of time to frame service scheduling and employment terms and conditions.
29
30 Developing this, Rubery et al. (2015: 753) propose the concept of 'fragmented time', that draws on
31
32 six indexes including payment for time in work-related activities (e.g. travel), insecurity via zero-
33
34 hours contracts, variable and/or extended schedules, time constrained work and work schedules
35
36 that meet worker preferences. Broadly, these indexes evidence adoption of zero-hour contracts and
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38 episodic working (Moore and Tailby, 2015), both of which facilitate removal of unproductive time as
39
40 demanded in a marketised, cost-constrained context.
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48 Zero-hour contracts describe arrangements where the employer is not obliged to offer, nor the
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50 worker to accept, hours of work (Alakeson and D'arcy, 2014). They are a long-standing form of non-
51
52 standard employment relationship:
53

54
55 'in the domiciliary care part of the [social care] sector, zero-hour contracts have become
56
57 standard and predate the current period of austerity' Alakeson and D'arcy (2014: 9).
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3 UK figures suggest that 70-80% of the domiciliary care workforce is employed on zero-hour contracts
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5 (Rubery et al., 2015, Bessa et al., 2013) and they are particularly prevalent in Wales (Burrowes,
6
7 2015). Service providers argue that reliance upon them results from spot contracting and income
8
9 instability and associated risk is transferred to workers via insecure working arrangements
10
11 (Cunningham, 2010). Working hours are not guaranteed and can vary substantially from week to
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13 week, although in practice care workers often work long hours (Bessa et al., 2013).
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19 Domiciliary care workers also work episodically, that is, workers are unpaid for time available for
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21 work but not spent delivering care (Moore and Tailby, 2015). Combined with zero-hour contracts,
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23 workers are paid only in the concentrated daily periods where there is care demand and not usually
24
25 in-between, even where available for work (Rubery et al., 2015). Strict time-based commissioning
26
27 underpins this, as service providers also only receive payment for hours of care delivered (Rubery et
28
29 al., 2015). Additionally, workers are not typically paid for travel time between care recipients (Bessa
30
31 et al., 2013) which incurs substantial cost for care workers, as UKHCA (2015a) estimates that
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33 approaching 20% of working time is spent travelling. Episodic working thus results in long working
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35 hours, many of which are unpaid.
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41 Following Bee et al. (2008), this article adds visit length to fragmented time's definition. Rubery et al.
42
43 (2015) included time constrained work in their fragmented time indexes, but had insufficient data to
44
45 include visit length and this is a key contribution of this paper. Commissioner emphasis on cost and
46
47 efficiency has increased the incidence of very short visits e.g. 15 to 30 minutes (UKHCA, 2015c). This
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49 further fragments working time, as care workers can spend as much (unpaid) time travelling
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51 between visits as they spend in delivering care. It also results in work intensification, as workers are
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53 pressured to do more in less time (Broadbent, 2014) and are unable to deliver the level of care
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55 required (Atkinson et al., 2016). Short visits are additionally problematic as time allowed often takes
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3 little account of the complexity of care needs and actual care delivery may well exceed the time
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5 scheduled for it (Rubery et al., 2015), meaning that workers are unpaid for care delivered.
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10 Marketisation has thus meant that most domiciliary care employment relationships are predicated
11
12 on fragmented time practices. This creates difficulties for both care workers and service providers.
13
14 For care workers, job dissatisfaction is likely (Rubery et al., 2015). The intrinsic satisfaction that
15
16 arises from the relational nature of care, and is widely accepted to be important to service quality
17
18 (Huang and Gamble, 2015), can co-exist with dissatisfaction arising from extrinsic factors (Carr, 2014)
19
20 but only buffers their detrimental impact to a certain extent (King et al., 2013). Extrinsic
21
22 dissatisfaction amongst care workers is thus widespread (Hebson et al., 2015) and associated with
23
24 stress (Cooke and Bartram, 2015) and burnout, characterised by emotional exhaustion and a low
25
26 sense of personal accomplishment, where pressures prevent deliver of high quality care (Taris et al.,
27
28 2003). Such job dissatisfaction and work-related stress are higher in UK social care employees than
29
30 other international contexts and related to poorer employment practice (Chen, 2014). While
31
32 research on fragmented time is limited, it is likely to be particularly problematic for care worker
33
34 (dis)satisfaction. Zero-hour contracts (Burrowes, 2015), episodic working and unpaid travel time
35
36 (Rubery et al., 2015) create an unattractive employment proposition and deter entry to the sector.
37
38 For example, retail work is perceived to be preferable, having fixed shifts and being less stressful
39
40 (Broadbent, 2014). Research in Canada further demonstrates that non-standard hours and casual
41
42 employment contracts create dissatisfaction and stress in domiciliary care workers (Zeytinoglu et al.,
43
44 2015). Care workers struggle to reconcile the competing demands of management and care
45
46 recipients, and, while limited, evidence is emerging of links to increased labour turnover (Taris et al.,
47
48 2003). Zeytinoglu et al. (2015) suggest stress increases in shorter visits that create work
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50 intensification as care workers are required to work faster. Interestingly, Brown and Korczynski
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52 (2010) argue that the nature of care means workers continue to offer discretionary effort to deliver
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54 good care to recipients, even when lowering commitment to service providers. The potential for
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3 burnout is, however, evident. For workers, these factors have negative consequences for well-being,
4 which are likely to be reflected in care recipient experiences, as is explored in the following section.
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6 For service providers, fragmented time drives, at least in part, recruitment and retention difficulties
7
8 (Cunningham, 2016, Broadbent, 2014) with shortages in both required numbers and standard of
9
10 workers (Francis and Netten, 2004). In Wales, 1,100 (6%) domiciliary care jobs were vacant in 2013
11
12 (CCW, 2014) and labour turnover ran at 30% in 2015 (UKHCA, 2015c). Service providers thus struggle
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14 to reconcile the competing demands of financial constraints and service delivery in the face of acute
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16 labour shortages.
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25 Care Quality

26 There are many, contested definitions of care quality (Atkinson et al., 2016) and it is conceptualised
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28 here as the lived, subjective experiences of care recipients (Bee et al., 2008), which is important in
29
30 examining facets of care meaningful to care recipients. For example, in social care, Iparraguirre and
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32 Ma (2015) adopt support for retaining control over day-to-day activities. In emergency care, Shankar
33
34 et al. (2013) include respect for care recipients' values, preferences and needs and, in mental health,
35
36 Bee et al. (2008) focus on length of visit, perceived care worker motivation and continuity of contact.
37
38 There is thus a strong case for using subjective experiences and, returning to domiciliary care, this
39
40 article draws on Francis and Netten's (2004) core dimensions of care quality, that is, continuity,
41
42 reliability and flexibility. Continuity refers to consistency of care worker(s) attending a care recipient
43
44 and is critical when delivering an intimate service (Eborall et al., 2010); reliability refers to care
45
46 workers fulfilling scheduled visits and arriving punctually; and flexibility describes the ability of a care
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48 worker to deliver beyond the care plan, the document which records care recipient needs. The
49
50 research question here is how fragmented time affects this care quality. Despite wider research that
51
52 clearly demonstrates employment practice/service quality relationships (Whyman et al., 2015),
53
54 there is no research that explicitly links employment practice, and more particularly fragmented
55
56 time, to care quality, only research that suggests tentative links (Broadbent, 2014, Cunningham,
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3 2016). This article adopts an inductive approach to examining these relationships and they are later
4
5 developed through analysis.
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8 9 Research Context and Methods

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11 The article draws from a Welsh Government-funded project that investigated employment practice
12 and its implications for recruitment, retention and care quality in Welsh domiciliary care (Atkinson et
13 al., 2016). Like many Western nations, domiciliary care is a high priority for Welsh Government, as
14 demand for domiciliary care grows as the population ages (Age_Cymru, 2015). Reflecting typical
15 patterns of marketization, 22 Welsh local authorities commission nearly 80% of domiciliary care
16 (StatsWales, 2015) from around 336 independent (private and voluntary) sector providers (CCW,
17 2014). Employment is thus mainly in the independent sector, where around two-thirds of the 18,000
18 strong domiciliary care workforce is based (UKHCA, 2015c).
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30 Qualitative data collection was undertaken, which is appropriate to exploration of an under-
31 researched area and to generating rich understanding. In autumn 2015, using a funder-provided
32 contact database, the researchers worked with gate-keepers in each local authority to generate
33 access to participants (Table 1). Gate-keepers sent invitations to attend focus groups to service
34 providers on their email distribution lists, and service providers circulated care worker specific email
35 invitations to their workforces. Eight focus groups lasting 60—90 minutes were held, two in each of
36 the four regions of Wales, four for service providers and four for care workers. Attendance was
37 voluntary and care worker participation was incentivised via a £20 gift voucher to compensate for
38 travel expenses and unpaid working time. 10 face-to-face/telephone interviews were also conducted
39 for those who were unable to attend scheduled focus groups. In total, 32 service providers and 41
40 care workers participated.
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55 Table 1 here
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3 For care workers, a demographic data capture form was used and participants across a range of
4 categories were sought, including gender, age and ethnicity. Thirty-three (80%) of the care worker
5 participants were female and they were distributed across a full range of age categories (three were
6 under 21; 10 were 21-30,; seven were 30-40; nine were 40-50; five were 50-60; two were over 60;
7 and 5 did not specify their age. Ethnic breakdown included 1 black participant, 1 mixed race, 1 who
8 did not specify and all other participants (38, 93%) described themselves as various combinations of
9 White British/White Welsh. While not a 'representative' sample, it broadly reflected the Welsh adult
10 social care workforce (figures are not available for domiciliary care) in which 80% are female, 86%
11 are white and most are aged over 30 (CCW, 2014). Wales is perhaps unusual in not having
12 substantial reliance on migrant labour and, while acknowledging the importance of this issue in
13 many contexts (Green and Ayalon, 2017), it is not a matter that is evidenced in the data nor
14 developed in the paper. Finally, care workers were asked to specify their contract type and 9 (7 of
15 whom who worked for local authorities) were on permanent, guaranteed-hours contracts and 2 on
16 fixed term (not guaranteed-hours) contracts with the remainder (30, 73%) being on zero-hours
17 contracts. This again reflects the national picture in Wales (StatsWales, 2015).

18
19 Again using the funder-provided contact database, the research team emailed invitations to
20 commissioners in all 22 local authorities and in this way arranged seven telephone interviews. This
21 gave 80 participants in total. Three Care and Social Services Inspectorate Wales-led (CSSIW)
22 workshops that formed part of a domiciliary care review (CSSIW, 2016) were additionally attended.
23 This added 33 participants, 17 commissioners and 16 service providers, giving 113 participants in
24 total. All participants worked in domiciliary care, except one care worker based in learning
25 disabilities, and break down by sector comprised: 8 local authority providers and 10 care workers;
26 15 private sector providers and 24 care workers; and 9 voluntary sector providers and 7 care
27 workers. Around three quarters of each group was drawn from the independent sector, which
28 reflects national patterns of care delivery (StatsWales, 2015). Project time constraints meant that it
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3 was not possible to gain ethical approval to interview care recipients, rather participants' views were
4 elicited as to what constituted good quality care.
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8 The article reports a subset of project data related to fragmented time. Full focus groups schedules
9 are available in the funder report (Atkinson et al., 2016). All interviews/focus groups were recorded
10 and fully transcribed. Detailed notes were taken and transcribed at the CSSIW workshops. Thematic
11 data analysis (King, 2004) was undertaken, transcripts being subjected to close reading and excerpts
12 coded that were relevant to fragmented time, recruitment and retention and care quality and their
13 inter-relationships. Initially each focus group transcript was analysed, then all service provider and
14 care worker data were combined into two templates before this data and commissioner interview
15 data was finally combined into one template. Relationships were inductively developed, integrating
16 fragmented time, as per Rubery et al. (2015), with Francis and Netton's (2004) dimensions of care
17 quality (summarised in Table 2). Throughout detailed discussion took place to ensure consistency
18 and shared researcher understanding. Data is presented by attaching commissioner, service provider
19 and care worker labels and the focus group from which it was gathered is indicated.
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41 Findings and Discussion

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43 This section first demonstrates the implications of neoliberal structures and marketization for the
44 employment relationship, exploring in particular fragmented time (Rubery et al., 2015), and then
45 evidences its detriment to care quality using Francis and Netten's (2004) core dimensions.
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52 Marketisation and Fragmented Time

53 While a detailed review of external commissioning practice is beyond the scope of this paper, the
54 impact of marketization was apparent. Local authority practice created substantial instability for
55 service providers as most commissioners operated Framework Agreements (Bessa et al., 2013),
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3 coupled with widespread use of spot contracts (Knapp et al., 2001) using time-based commissioning,
4 all purchasing the majority of care in short blocks of 30 minutes or less. All commissioners
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6 acknowledged the insecurity for service providers, as income flows were uncertain and would
7
8 immediately cease on care recipient hospitalisation or death. Commissioners equally acknowledged
9
10 funding constraints (Age_Cymru, 2015) and some argued that care had '*unfortunately*' become a
11
12 business and local authorities were battling austerity and '*there's very little money out there to [fund*
13
14 *care at an appropriate level]....'*. Interview 1. Indeed, monopsony pressures suppressed rates (as per
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16 Cavendish, 2013) to around £14-15 per hour, below the UKHCA (2015b) calculated hourly cost of
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18 £16.70.
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27 Commissioners recognised that low and insecure payments could negatively influence the
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29 employment practice of independent service providers (confirming Rubery and Urwin, 2011,
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31 Cunningham, 2008) but budget constraints dominated.
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34 *It's a challenge, both for the sector... making sure they have got good [care] standards, but*
35 *also for local authorities because to pay for that comes at a cost. With a shrinking budget.*
36
37 *From a local authority perspective, I don't think any of us would ever disagree that there*
38 *should be appropriate terms and conditions and [care workers] should be paid the*
39 *appropriate rate. But... [local authorities struggle to influence this]. CSSIW Workshop 2*
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49 No local authority regulated care worker employment terms and conditions via their Framework
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51 Agreements (as per Bessa et al., 2013) and monitoring addressed only compliance with standard
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53 employment legislation. Some commissioners expressed a desire to integrate Unison's Ethical Care
54
55 Charter into future frameworks but, given funding constraints, this seemed a remote aspiration.
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57 Marketization thus had substantial implications which are starkly demonstrated in what follows, first
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3 in respect of fragmented time, where service providers transferred commissioning risk to care
4 workers and relied almost exclusively upon zero-hour contract arrangements, operated episodic
5 working practices and were constrained by commissioning in visit length, and second for care
6 quality.
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14 Zero Hours Contracts

15 While local authority providers operated standard local government terms and conditions and
16 offered guaranteed hours, in the independent sector zero-hours contracts were explicitly related to
17 commissioning-led income insecurity (Burrowes, 2015):
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23 *There is not a lack of hours [for care workers]...but we can never guarantee them because of*
24 *the [unstable] nature of the business. Service Provider, Focus Group 2*
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28 Two independent providers sought to reduce insecurity by offering (some) guaranteed-hour
29 contracts, but this was problematic and one noted that *'it's very hard if they lose [care recipients], I*
30 *end up giving them office work.'* Focus Group 4. Care workers in the independent sector, where
31 nearly all worked on zero-hour contracts, expressed insecurity and concern:
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37 *At the moment, we've got loads of hours but as soon as someone goes into hospital, we lose*
38 *like four calls a day....then you get hardly anything for the week. Care Worker, Focus Group 3*
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43 *You get the hours. Never, ever have I been without, but still it's just like, what if? You feel like*
44 *you don't have a leg to stand on. Care Worker, Focus Group 1*
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48 Most care workers expressed a strong preference for guaranteed-hour contracts, although some,
49 mainly mothers and students, welcomed the flexibility zero-hour contracts offered (Atkinson et al.,
50 2016).
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3 Zero hours contracts were strongly associated with difficulties in both recruitment and retention.

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5 Independent providers argued it was hard to attract workers into the sector when total flexibility in
6
7 working time was demanded:

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10 *We are restricted because we expect total flexibility and that narrows down the [labour]*
11 *market.... when people come on board it's a zero-hour contract.... It doesn't always work in*
12 *our favour [for recruitment]. Service Provider, Focus Group 4*
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18 Tellingly, most of the local authority care workers had previously worked in the independent sector
19 and suggested that reducing insecurity had been central to their decision to move local authority
20 employment. Lack of guaranteed hours thus contributed to a highly transient workforce that moved
21 around independent providers for often minor improvements in terms and conditions. Resulting
22 labour shortages meant that care packages could remain un-commissioned for lengthy periods,
23 leading to bed-blocking (Marsh, 2016), and creating a vicious circle of long working hours (Bessa et
24 al., 2013), resulting in stress and burnout (as per Taris et al., 2003):
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34 *We expect a lot from them, they are very tired. Because there is a [shortage]. We are ten*
35 *care workers down, 250 hours, which is a lot. Service Provider, Focus Group 4*
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41 Zero-hours contracts were thus implicated in labour shortages through both sickness absence and
42 turnover (Rubery and Urwin, 2011). Use of the contracts confirms the insecurity aspect of Rubery et
43 al.'s (2015) fragmented time index, and findings here also evidence other indexes e.g. variable
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Episodic Working

Strict time-based commissioning, allowing payment for contact time only, created a high incidence
of episodic working (Moore and Tailby, 2015) for all independent sector workers. Service providers
recognised that care workers resented unpaid waiting time, but argued it was beyond their control:

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3 *Trying to get staff to understand is really, really hard.... Our main [calls] are between half-six*
4 *and half-nine in the morning, then lunchtime.... and then tea to bedtime. But in between,*
5 *there's nothing. So staff are like, "Well, I'm out for six hours and you've only given me three",*
6 *but if there's only three hours and nothing in between.... Service Provider Focus Group 3*
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13 Most care workers were vocal in their dissatisfaction with episodic working, as non-payment for
14 waiting time resulted in long hours and low earnings (as per Rubery et al., 2015):
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18 *The most frustrating thing is.... you're starting at eight in the morning.... you make it home at*
19 *ten at night, and if you tally up all the amount of hours that you get [paid for] ... five hours....*
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22 *Care Worker Focus Group 4*
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29 This was compounded by non-payment for travel time which, particularly in rural areas and for
30 numerous short visits some distance apart, could account for a substantial proportion of a care
31 worker's 'run', or visit schedule (as per UKHCA, 2015a). Care workers were acutely aware of these
32 pressures and resentful, arguing that they were often doing 'full-time work for part-time pay'.
33 *Care Worker Focus Group 1*
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44 Episodic working in the independent sector thus created dissatisfaction with long, demanding
45 working days that generated high levels of stress (as per Cooke and Bartram, 2015) and burnout
46 (Taris et al., 2003). Both sickness absence and labour turnover resulted (Rubery et al., 2015) and an
47 exodus to other low-paid sectors. Retail employment, for example, was seen as more attractive as,
48 despite frequent use of zero-hour contracts, working time was not episodic and the work was not as
49 stressful (confirming Broadbent, 2014, Brown and Korczynski, 2010).
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Visit length

Commissioning practice also constrained time available for care delivery (Rubery et al., 2015), with short visits prevalent across all providers, both local authority and independent sector. Provider and care worker data evidence that the overwhelming majority of visits were 30 minutes or less and even local authority care workers on guaranteed-hour contracts were required to deliver care via primarily short visits. Commissioners argued that 15 minutes visits were atypical and used only for administering medication but provider and care worker data did not support this. Visits of 30 minutes and even less were deemed inadequate to deliver good quality care and had negative implications for recruitment and retention, as evidenced by one learning disability care worker whose work afforded longer visit times:

The one thing that drew me to this was, we don't do less than an hour calls. Cos there's no way in the world could I work, well I would work but I'd fight it. You can't do someone's breakfast in half an hour and get them up and dressed. Care Worker, Telephone interview 2

As this suggests, short visits created substantial pressure and work intensification (Broadbent, 2014).

If it is only a ten minute call and you are running late already.... you literally have two minutes. It can be quite stressful. Care Worker, Focus Group 1

You try and do your best but time restricts you, there's too much pressure. Care Worker, Focus Group 4

'Tired' was a description frequently used by all care workers (as per Zeytinoglu et al., 2015), and mirrored by service providers who suggested care workers could suffer from physical and emotional exhaustion. Labour shortages also created a vicious circle of long working hours (Bessa et al., 2013) and sickness absence, resulting in stress and burnout (as per Taris et al., 2003):

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3 *We expect a lot from them, they are very tired. Because there is a [shortage]. We are ten care*
4
5 *workers down, 250 hours which is a lot. Service Provider Focus Group 2*
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9 *When I ask them [existing care workers] to do more, like I've had to ask them to at the*
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11 *moment, that can create sickness.... Service Provider Focus Group 3*
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17 While most care workers experienced intrinsic job satisfaction derived from caring (Carr, 2014), this
18 co-existed alongside extrinsic dissatisfaction (King et al., 2013), particularly evident in respect of
19 fragmented time. Independent providers all questioned the sustainability of current care models
20 given the stress and burnout occasioned for care workers (Taris et al., 2003) and the resulting
21 sickness absence, labour turnover and labour shortages (Rubery et al., 2015).
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32 While local authority care workers were employed on better terms and conditions, they comprise a
33 small proportion of domiciliary care workers in Wales (CCW, 2014) and nevertheless worked with
34 primarily short visit times. For the majority, employed in the independent sector, commissioning
35 practice structured an employment relationship dominated by fragmented time, resulting in
36 recruitment and retention difficulties and consequent labour shortages. These structural conditions
37 inform understanding of the care worker/recipient interactions that determine care quality.
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49 **Fragmented time and care quality**

50 *"No one sets out to provide bad care, but you're dragged to it, dragged into the gutter" Service*
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52 *Provider, CSSIW Focus Group 1*
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55 This quote powerfully illustrates service provider concerns around marketisation processes that
56 drive fragmented time and diminish care quality. These concerns were shared by care workers who
57 argued that time was critical to effective care delivery:
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3 *You need time to do quality care. You do need the time. Care worker Focus Group 3*
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6 Indeed, lack of time was argued to be tantamount to abuse. More specifically, the detriment of
7
8 fragmented time to care quality was evident against the dimensions of continuity, reliability and
9
10 flexibility (Francis and Netten, 2004). This is summarised in Table 2 and supported below by rich
11
12 participant narratives.
13
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15
16 Table 2 here
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18
19 Continuity, the consistency of care worker visiting a care recipient, was consistently cited as
20
21 important and was explicitly required by all commissioners. Care workers also argued its importance
22
23 in building relationships with care recipients when providing an intimate service (Eborall et al., 2010)
24
25 and expressed dissatisfaction when this was not possible. It underpinned high quality, relational
26
27 care (Atkinson and Lucas, 2013):
28
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30
31 *Continuity is a big part.... she has dementia, sometimes she just forgets to eat. It's little*
32
33 *things like that we pick up on because we know her. Other carers will just put the food back*
34
35 *in the fridge, they'll assume that she's eaten something earlier on in the day. It takes us who*
36
37 *know her well to know that she's just forgotten to eat. Care Worker Focus Group 2*
38

39
40 *It's hard to build up that relationship with somebody, to have them naked in front of you so*
41
42 *you can put them in the shower and.... you've got that confidence and then they're moving*
43
44 *you on now to somebody else." Care Worker Focus Group 1*
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51 Zero hours contracts mitigated against continuity. First for care workers in creating unstable and
52
53 changeable working patterns. Second for service providers, as care workers could and did refuse
54
55 shifts offered. These contracts contributed to recruitment and retention difficulties:
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3 *...we've talked about zero-hours contracts and [their] issues.... people move around, they don't*
4 *want to stay in that job; that affects [continuity]. It's just like a big circle really. Service*
5 *Provider CSSIW Focus Group 3*
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10 Episodic working practices also risked undermining care worker commitment to care delivery:

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13 *You've got to drive here, drive there..... then you start considering the logistical impact,*
14 *financially and think, what is the point? that contradicts every reason you're here.*
15
16
17 *Because you start getting a little bit disgruntled. Care Worker Focus Group 4*
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21 This fed both labour turnover and sickness absence through worker dissatisfaction, stress and
22 burnout (as per Taris et al., 2003). Continuity was thus compromised by both unstable working
23 patterns and the resulting labour shortages, as independent providers struggled to resource
24 provision from a highly transient workforce.
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33 Reliability, arriving when scheduled and promptly, was central to positive care recipient experiences:

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36 *One of our clients is very time conscious, she won't let you in early, she won't let you in late,*
37 *and that brings a stress then because.... the constant conversation is, "I don't understand*
38 *why you're late". Care Worker Focus Group 2*
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44 Zero-hours contracts and resulting labour shortages could, at the extreme, lead to non-fulfilment of
45 scheduled care. More commonly, episodic working and insufficient (unpaid) travel time caused late
46 arrival:
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51 *Travel times can be an issue.... we'll have to go from X to X in five minutes, and you just can't*
52 *do it. It's a fifteen minute trip [so we are] late and for the rest of the day we find ourselves*
53 *constantly.... catching up with the calls. Care Worker Focus Group 1*
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3 Short visits compounded these difficulties, as unrealistic time allocations occasioned delays and
4
5 reduced visit times further. The work intensification and poor care that resulted for all was
6
7 extremely stressful:
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10 *We do toileting, food and medication. To do all that in fifteen minutes and do it to the best of*
11 *your ability, you need more time. Care Worker Focus Group 4*
12

13 *It is so wrong, but I've heard about times when care workers have had to feed people their*
14 *lunch as they are on the commode. Service Provider, CCSIW Focus Group 2*
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23 Attempts to offset these pressures could result in substantially reduced care, by for example,
24 concurrent scheduling of visits that created extra stress for care workers. Care commitments were
25 thus difficult to fulfil given labour shortages and high labour turnover. Care recipients experienced
26 late or missed visits which reduced their capacity to retain control over their lives (Iparraguirre and
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Ma, 2015).

Flexibility, the third dimension related to addressing care recipient needs beyond the care plan, was
also problematic. (Lack of) flexibility was one of the biggest sources of dissatisfaction for most care
workers, as it challenged their understandings of good care. Zero-hour contracts meant time was not
generally made available for staff training, meaning they lacked necessary skills. They further
created unstable working schedules that left some care workers lacking the knowledge of care
recipients and their needs required to exercise autonomy. Episodic practices and late arrival
combined to make already short visits even shorter and rendered care workers unable to meet the
care plan requirements, let alone go beyond it:

If it's a half hour with someone who's got dementia, then every time you go in you need to
explain who you are, why you're there, why you've got to do what you've got to do. That can

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2
3 *take fifteen minutes, and then you've still got to wash them, dress them, do the breakfast,*
4 *make the bed, empty the commode. It becomes a fifteen-minute call because you've spent so*
5 *long trying to reassure them that you're there to help them. Care Worker Focus Group 2*
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13 Visit length, as evidenced here, was frequently not adjusted for complexity of need (as per Rubery et
14 al., 2015) and so even 30 minute visits, the maximum length of most visits across local authority and
15 independent sector providers, were insufficient to deliver good care. Care workers argued for longer
16 visits that offered the flexibility for them to offer 'proper' (flexible) care and promote the
17 independence espoused by policy:
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25 *Doing personal care and things around the house for them is important, but [so is] actually*
26 *sitting down and just knowing that I haven't got to rush off. Care Worker Focus Group 4*
27
28

29 *How can we be promoting independence, doing all the things that we want to be doing, if*
30 *we're kept to a twenty minute call. It's impossible, it can't be done. Care Worker Focus Group 2*
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39 These time pressures were deeply problematic, creating stress and burnout for all care workers:
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41

42 *The last thing they want to feel is rushed, especially if you're a ninety-eight year old who gets a*
43 *little bit breathless. The last thing he wants is, "Come on now, we've got to go, we've got to do*
44 *meds now." And he's like, "Hang on a minute, I haven't had my tea yet". Care Worker Focus*
45 *Group 3*
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52 Additionally, burnout could lead to disassociation which reduces flexibility still further (Taris et al.,
53 2003). The delivering of outcomes-based care, central to policy aspirations (e.g.
54 Welsh_Government, 2015), was compromised by lack of flexibility.
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3 It should be noted that most care workers were deeply committed to domiciliary care and described
4 leaving to work, for example, in retail, as 'going over to the dark side'. Job satisfaction was widely
5 linked to exercise of discretionary behaviour (Huang and Gamble, 2015) and there were repeated
6 examples of care workers doing shopping or returning to offer care in their own time to ensure good
7 care. Some service providers expressed concern over professional boundaries, but care workers
8 argued that it was the only way to ensure good care. This effort was maintained despite
9 dissatisfaction with fragmented time and created a hidden burden of stress and work intensification
10 (Broadbent, 2014). Yet despite maintaining commitment to care recipients, many did not maintain
11 commitment to service providers (Brown and Korczynski, 2010). Their dissatisfaction with
12 constraints on care provision was the biggest factor in care workers leaving the employer, through
13 both the time pressures that led to both poor care and stress and burnout:

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*If we are expecting care workers to work long hours, to put in extra calls, it is going to have
an impact on the care that they provide. Not through being neglectful but because they are
so tired. Service Provider, Focus Group 1*

All participants argued that zero-hours contracts, episodic working and short visits compromised
continuity, reliability and flexibility of care, both directly and indirectly through the resulting
instability and work intensification, stress and burnout, sickness absence and labour turnover and
labour shortages.

Inevitably, this research has limitations. A key one is that it did not include care recipients,
nevertheless generating a valuable evidence-base from the perspective of commissioners, service
providers and care workers. In extending the research, it will be important to include care recipient
views on quality of care received. Further, the research is qualitative, rich perceptual data to identify
important relationships. Testing these relationships quantitatively will be an important next step,
using perhaps an index approach similar to Rubery et al.'s (2015) for both fragmented time and care

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3 quality. Despite these limitations, the paper evidences that fragmented time creates a dual burden
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5 for two vulnerable groups, the care workers who bear its hidden consequences (Brown and
6
7 Korczynski, 2010), and the care recipients who experience reduced care quality.
8
9

10 11 Conclusions

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14 This article explores aspects of employment practice in domiciliary care work to ask: what are the
15
16 consequences of fragmented time for care quality? It makes a valuable empirical addition to social
17
18 care employment research, particularly in reporting care worker perspectives on this question.
19

20
21 Drawing on Rubery's (2015) analysis of employment trends, it demonstrates that fragmentation and
22
23 flexibilisation in a highly feminised sector combine to create fragmented time and that this is
24
25 detrimental to care quality. Independent providers, who deliver around 80% of domiciliary care,
26
27 struggle to recruit and retain the necessary labour (Rubery and Urwin, 2011); care workers suffer
28
29 dis-satisfaction, stress and burnout (Taris et al., 2003); and care quality is compromised through lack
30
31 of continuity, reliability and flexibility. The research site is Wales, but similar international policy
32
33 contexts mean the findings have wider resonance (e.g. Cunningham et al., 2014, Broadbent, 2014).
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41 The article makes both empirical and theoretical contributions. Empirically, it confirms Rubery et
42
43 al.'s (2015) findings that fragmented time creates care worker detriment. It confirms many of the
44
45 indexes proposed for fragmented time, including (lack of) payment for work-related activities (e.g.
46
47 travel) and fragmented/variable/extended schedules. While Rubery et al. (2015) noted the time-
48
49 constrained nature of care work, they had insufficient data to include visit length in that index of
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51 fragmented time. Importantly then, this research provides evidence to extend its definition to
52
53 include visit length, noted as important in other care settings (Bee et al., 2008). Short visits were
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55 prevalent and substantially implicated in both work intensification and care worker stress and poor
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57 care for recipients. Rubery et al. (2015) demonstrate tensions arising from fragmented work
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3 *allocation*, i.e. zero hours contracts and episodic working, but this article evidences that its
4
5 fragmented *construction*, i.e. short visit length, is equally problematic. Importantly, this applies not
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7 only to visits of 15 minutes or less, but equally to longer visits that are nevertheless insufficient to
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9 address complex care needs. The extended definition of fragmented time is critical to understanding
10
11 the pressures that derive from both employer and care recipient demands and how these mutually
12
13 reinforce to create pressure for workers (Taris et al., 2003) and inferior care for recipients.
14

15
16 Employers, particularly in the independent sector, also experience substantial pressure. They
17
18 grapple with establishing an adequate workforce in the face of financial constraints arising from the
19
20 commissioning monopsony of local authorities within marketised social care. These empirical and
21
22 theoretical contributions advance research that has hinted at employment/care quality relationships
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24 (Broadbent, 2014, Cunningham, 2016) to evidence how particular features of the employment
25
26 relationship are detrimental to care quality.
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33 The findings also raise substantial policy concerns that dictate urgent review of commissioning
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35 mechanisms. It is questionable whether market approaches can deliver the employment practice
36
37 needed for high quality care (Rubery and Urwin, 2011). Local authority monopsony, both prior to
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39 and during austerity, has suppressed commissioning rates at potentially uneconomic levels and,
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41 coupled with widespread use of spot contracting and strict time-based commissioning, created the
42
43 fragmented time practices evidenced here. While it is hardly novel to suggest that domiciliary care is
44
45 inadequately funded, this article evidences a clear pathway from commissioning practice to service
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47 provider and care worker struggles to poor care quality. This builds an incontrovertible body of
48
49 evidence for policy-makers that high quality domiciliary care will not be delivered without more
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51 secure, better-funded commissioning that drives improved employment practice (Grimshaw et al.,
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53 2015, Rubery et al., 2013). Most domiciliary care is delivered in the independent sector creating, in
54
55 many countries, a 'race to the bottom' in employment (Cunningham, 2008). While voluntary
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57 frameworks exist, for example, Unison's Ethical Care Charter, these are unlikely to suffice in creating
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3 the good work that will underpin high quality care (Rubery and Urwin, 2011). Regulation may be
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5 needed.
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11 As noted at the outset, demand for domiciliary care is growing as Western populations age and the
12
13 offer of good quality employment is fundamental to its effective delivery (Kingsmill, 2014). This
14
15 exploration of fragmented time paints an alarming picture of tensions and pressures experienced by
16
17 care workers and service providers. Inevitably, negative consequences ensue for care quality in a
18
19 sector that both deals with one of society's most vulnerable groups and underpins the effective
20
21 functioning of healthcare systems.
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Table 1: Participants

Participants	Total number	Interview - telephone	Interview -face to face	Focus group - CSSIW	Focus group - project
Local authority commissioners	24	7	0	17	0
Provider managers	48	2	4	16	26
Care workers	41	0	4	0	37
Total	113	9	8	33	63

Table 2: The implications of fragmented time for care work and care quality

Implications for Fragmented time	Care workers and service providers	Continuity	Reliability	Flexibility
Zero hours contracts	Care workers <ul style="list-style-type: none"> • Instability • Work intensification • Dissatisfaction • Stress and burnout 	Highly variable working patterns; substantial labour turnover Outcome: many different care workers visit care recipient	Highly variable working patterns; substantial labour turnover Outcome: visits unfulfilled or care workers arrive late	Highly variable working patterns; limited access to training Outcome: care workers lack both knowledge of care recipient and skills to deliver flexible care
Episodic working	Service providers <ul style="list-style-type: none"> • Recruitment 	Substantial labour turnover Outcome: many different care workers visit care recipient	Inadequate travel time and scheduling of concurrent visits Outcome: care workers arrive late and call times are reduced	Inadequate time with care recipient

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	difficulties <ul style="list-style-type: none"> • High labour turnover • Sickness absence • Labour shortages 			Outcome: care workers struggle to fulfil care plan and cannot go beyond it
Visit length		Inadequate time with care recipient Work intensification, stress and burnout, sickness absence Outcome: many different care workers visit care recipient	Inadequate time with care recipient Work intensification, stress and burnout, sickness absence Outcome: care workers arrive late and call times are shortened	Inadequate time with care recipient Work intensification, stress and burnout, sickness absence Outcome: disassociation creates reduced flexibility

ⁱ The UKHCA’s minimum price of domiciliary care includes: payment of National Minimum/Living Wage, unsocial hours payments, travel time and costs, staff on-costs, training time, general running costs (e.g. office staff, equipment and premises costs) and net profit/surplus of 3% p.a.