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Fragmented time and domiciliary care quality

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Abstract

Purpose – The purpose of this paper is to examine the marketization of domiciliary care, its consequences for employment practice, specifically fragmented time, and the implications for care quality.

Design/methodology/approach – 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/implications – 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 it. Current care commissioning practices need urgent review.

Originality/value – The research extends the definition of fragmented time and integrates 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 Marketization, Care quality, Domiciliary care, Fragmented time

Paper type Research paper

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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 a 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-hour contracts (Rubery and Urwin, 2011). Second, flexibilisation of employment being demand- rather than supply-led, again with resultant workforce insecurity. Finally, feminisation of employment,



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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, p. 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 quality in other contexts is well-established (Whyman *et al.*, 2015), the paper addresses the research question:

RQ1. What are the consequences of fragmented time for care quality?

The paper makes a valuable empirical contribution to the social care employment research base (Cooke and Bartram, 2015), importantly adding care workers’ views (Cunningham, 2010) not just on their employment situation, but also on care quality. Theoretically, it both confirms Rubery *et al.*’s (2015) definition of fragmented time, evidencing an employment offer predicated upon zero-hour contracts and episodic working, and extends it in adding visit length (Bee *et al.*, 2008). Further, it integrates fragmented time with Francis and Netten’s (2004) dimensions of good care to demonstrate the detriment to quality that fragmented time brings in reducing continuity, reliability and flexibility of care. This moves beyond the thus far tentative links proposed in existing domiciliary care research (Broadbent, 2014; Cunningham, 2016) to evidence that poor employment practice compromises care quality. For policy makers, the paper demonstrates substantial tensions between policy’s aspirations for high-quality care and funding/commissioning practice that mitigates against good employment practice.

The paper proceeds by outlining the marketization of domiciliary care and the implications for social care employment relationships. It then theoretically frames fragmented time and care quality, before presenting research methods and findings/discussion. It concludes with research contributions and implications.

Marketisation and domiciliary care employment relationships

In many neoliberal economies, there has been marked reduction in the state provision of domiciliary care over recent decades (Cunningham, 2008). A shift to marketised relationships has occurred in which the state, via local authorities, commissions most domiciliary care from independent (private and voluntary) sector service providers (Cunningham *et al.*, 2014). Understanding of commissioning is essential to the examination of both wider employment practice (Rubery *et al.*, 2013) and, specifically, fragmented time (Rubery *et al.*, 2015). Marketisation draws on supposedly efficient business principles and aims to improve care quality. In practice, the external commissioning of care has long been associated with quality concerns, related in large part to the cost pressures that have dominated local authority commissioner agendas (Cunningham, 2010). Indeed, Cavendish’s (2013) review of UK care failures argued that the local authority monopsony of commissioning suppresses rates and UK Home Care Association, the employers association for domiciliary care providers (UKHCA, 2015a), reports that care is often commissioned at less than its cost price[1]. Inadequate funding is compounded by insecure commissioning arrangements, with a move away from block contracts, where an agreed number of hours are purchased whether used or not, to spot contracts, where payment is only made if care is taken up (see Knapp *et al.*, 2001 for detailed explanation). Time is the unit of account adopted (Rubery *et al.*, 2015) and domiciliary care provision is typically measured in minutes with, in a drive for efficiency, the increased use of short visits of 15 and 30 min or less (Bessa *et al.*, 2013). Using spot contracts, commissioners operate framework agreements that accredit service providers as operating at an appropriate quality level (Bessa *et al.*, 2013) and providers submit tenders for care packages on a price-by-case arrangement. In combination, these practices have created inadequate and insecure funding streams for independent service providers. 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 practice is widespread in both the private (Rubery and Urwin, 2011) and voluntary sectors, where Cunningham (2008) describes a “race to the bottom” (p. 1033). Green and Ayalon (2017) echo this, arguing that domiciliary care workers are susceptible to various forms of abuse and calling for closer scrutiny of their working conditions. While their research focuses particularly on migrant labour, the issues are nevertheless relevant to the predominantly Welsh workforce considered here. This paper explores one important aspect of employment, fragmented time (Rubery *et al.*, 2015) and its implications for care quality.

Fragmented time

The paper builds on Rubery *et al.*'s (2015) argument that time is a critical issue within domiciliary care. This flows both from commissioning practice, discussed above, that adopts time as a unit of account and the use of time to frame service scheduling and employment terms and conditions. Developing this, Rubery *et al.* (2015, p. 753) propose the concept of “fragmented time” that draws on six indexes including payment for time in work-related activities (e.g. travel), insecurity via zero-hour contracts, variable and/or extended schedules, time constrained work and work schedules that meet worker preferences. Broadly, these indexes evidence adoption of zero-hour contracts and episodic working (Moore and Tailby, 2015), both of which facilitate removal of unproductive time as demanded in a marketised, cost-constrained context.

Zero-hour contracts describe arrangements where the employer is not obliged to offer, nor the worker to accept, hours of work (Alakeson and D'arcy, 2014). They are a long-standing form of non-standard employment relationship:

[...] in the domiciliary care part of the [social care] sector, zero-hour contracts have become standard and predate the current period of austerity. (Alakeson and D'arcy, 2014, p. 9)

UK figures suggest that 70–80 per cent of the domiciliary care workforce is employed on zero-hour contracts (Rubery *et al.*, 2015; Bessa *et al.*, 2013) and they are particularly prevalent in Wales (Burrowes, 2015). Service providers argue that reliance upon them results from spot contracting and income instability and associated risk is transferred to workers via insecure working arrangements (Cunningham, 2010). Working hours are not guaranteed and can vary substantially from week to week, although in practice care workers often work long hours (Bessa *et al.*, 2013).

Domiciliary care workers also work episodically, that is, workers are unpaid for time available for work but not spent delivering care (Moore and Tailby, 2015). Combined with zero-hour contracts, workers are paid only in the concentrated daily periods where there is care demand and not usually in-between, even where available for work (Rubery *et al.*, 2015). Strict time-based commissioning underpins this, as service providers also only receive payment for hours of care delivered (Rubery *et al.*, 2015). Additionally, workers are not typically paid for travel time between care recipients (Bessa *et al.*, 2013) which incurs substantial cost for care workers, as UKHCA (2015a) estimates that approaching 20 per cent of working time is spent travelling. Episodic working thus results in long working hours, many of which are unpaid.

Following Bee *et al.* (2008), this paper adds visit length to fragmented time's definition. Rubery *et al.* (2015) included time constrained work in their fragmented time indexes, but had insufficient data to include visit length and this is a key contribution of this paper.

Commissioner emphasis on cost and efficiency has increased the incidence of very short visits e.g. 15–30 min (UKHCA, 2015c). This further fragments working time, as care workers can spend as much (unpaid) time travelling between visits as they spend in delivering care. It also results in work intensification, as workers are pressured to do more in less time (Broadbent, 2014) and are unable to deliver the level of care required (Atkinson *et al.*, 2016). Short visits are additionally problematic as time allowed often takes little account of the complexity of care needs and actual care delivery may well exceed the time scheduled for it (Rubery *et al.*, 2015), meaning that workers are unpaid for care delivered.

Marketisation has thus meant that most domiciliary care employment relationships are predicated on fragmented time practices. This creates difficulties for both care workers and service providers. For care workers, job dissatisfaction is likely (Rubery *et al.*, 2015). The intrinsic satisfaction that arises from the relational nature of care, and is widely accepted to be important to service quality (Huang and Gamble, 2015), can co-exist with dissatisfaction arising from extrinsic factors (Carr, 2014) but only buffers their detrimental impact to a certain extent (King *et al.*, 2013). Extrinsic dissatisfaction amongst care workers is thus widespread (Hebson *et al.*, 2015) and associated with stress (Cooke and Bartram, 2015) and burnout, characterised by emotional exhaustion and a low sense of personal accomplishment, where pressures prevent deliver of high-quality care (Taris *et al.*, 2003). Such job dissatisfaction and work-related stress are higher in UK social care employees than other international contexts and related to poorer employment practice (Chen, 2014). While research on fragmented time is limited, it is likely to be particularly problematic for care worker (dis)satisfaction. Zero-hour contracts (Burrowes, 2015), episodic working and unpaid travel time (Rubery *et al.*, 2015) create an unattractive employment proposition and deter entry to the sector. For example, retail work is perceived to be preferable, having fixed shifts and being less stressful (Broadbent, 2014). Research in Canada further demonstrates that non-standard hours and casual employment contracts create dissatisfaction and stress in domiciliary care workers (Zeytinoglu *et al.*, 2015). Care workers struggle to reconcile the competing demands of management and care recipients, and, while limited, evidence is emerging of links to increased labour turnover (Taris *et al.*, 2003). Zeytinoglu *et al.* (2015) suggest stress increases in shorter visits that create work intensification as care workers are required to work faster. Interestingly, Brown and Korczynski (2010) argue that the nature of care means workers continue to offer discretionary effort to deliver good care to recipients, even when lowering commitment to service providers. The potential for burnout is, however, evident. For workers, these factors have negative consequences for well-being, which are likely to be reflected in care recipient experiences, as is explored in the following section. For service providers, fragmented time drives, at least in part, recruitment and retention difficulties (Cunningham, 2016; Broadbent, 2014) with shortages in both required numbers and standard of workers (Francis and Netten, 2004). In Wales, 1,100 (6 per cent) domiciliary care jobs were vacant in 2013 (CCW, 2014) and labour turnover ran at 30 per cent in 2015 (UKHCA, 2015c). Service providers thus struggle to reconcile the competing demands of financial constraints and service delivery in the face of acute labour shortages.

Care quality

There are many, contested definitions of care quality (Atkinson *et al.*, 2016). It is conceptualised here as the lived, subjective experiences of care recipients (Bee *et al.*, 2008), which is important in examining facets of care meaningful to care recipients. For example, in social care, Iparraguirre and Ma (2015) adopt support for retaining control over day-to-day activities. In emergency care, Shankar *et al.* (2013) include respect for care recipients' values, preferences and needs and, in mental health, Bee *et al.* (2008) focus on length of visit, perceived care worker motivation and continuity of contact. There is thus a strong case for using subjective experiences and, returning to domiciliary care, this paper draws on

Francis and Netten's (2004) core dimensions of care quality, that is, continuity, reliability and flexibility. Continuity refers to the consistency of care worker(s) attending a care recipient and is critical when delivering an intimate service (Eborall *et al.*, 2010); reliability refers to care workers fulfilling scheduled visits and arriving punctually; and flexibility describes the ability of a care worker to deliver beyond the care plan, the document which records care recipient needs. The research question here is how fragmented time affects this care quality. Despite wider research that clearly demonstrates employment practice/service quality relationships (Whyman *et al.*, 2015), there is no research that explicitly links employment practice, and more particularly fragmented time, to care quality, only research that suggests tentative links (Broadbent, 2014; Cunningham, 2016). This paper adopts an inductive approach to examining these relationships and they are later developed through analysis.

Research context and methods

The paper draws from a Welsh Government-funded project that investigated employment practice and its implications for recruitment, retention and care quality in Welsh domiciliary care (Atkinson *et al.*, 2016). Like many western nations, domiciliary care is a high priority for Welsh Government, as demand for domiciliary care grows as the population ages (Age Cymru, 2015). Reflecting typical patterns of marketization, 22 Welsh local authorities commission nearly 80 per cent of domiciliary care from around 336 independent (private and voluntary) sector providers (CCW, 2014). Employment is thus mainly in the independent sector, where around two-thirds of the 18,000 strong domiciliary care workforce is based (UKHCA, 2015c).

Qualitative data collection was undertaken, which is appropriate to exploration of an under-researched area and to generating rich understanding. In Autumn 2015, using a funder-provided contact database, the researchers worked with gate-keepers in each local authority to generate access to participants (Table I). Gate-keepers sent invitations to attend focus groups to service providers on their e-mail distribution lists, and service providers circulated care worker specific e-mail invitations to their workforces. Eight focus groups lasting 60–90 min were held, two in each of the four regions of Wales, four for service providers and four for care workers. Attendance was voluntary and care worker participation was incentivised via a £20 gift voucher to compensate for travel expenses and unpaid working time. Ten face-to-face/telephone interviews were also conducted for those who were unable to attend scheduled focus groups. In total, 32 service providers and 41 care workers participated.

For care workers, a demographic data capture form was used and participants across a range of categories were sought, including gender, age and ethnicity. In total, 33 (80 per cent) of the care worker participants were female and they were distributed across a full range of age categories (three were under 21; ten were 21–30; seven were 30–40; nine were 40–50; five were 50–60; two were over 60; and five did not specify their age). Ethnic breakdown included one black participant, one mixed race, one who did not specify and all other participants (38, 93 per cent) described themselves as various combinations of White

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 I.
Participants

British/White Welsh. While not a “representative” sample, it broadly reflected the Welsh adult social care workforce (figures are not available for domiciliary care) in which 80 per cent are female, 86 per cent are white and most are aged over 30 (CCW, 2014). Wales is perhaps unusual in not having substantial reliance on migrant labour and, while acknowledging the importance of this issue in many contexts (Green and Ayalon, 2017), it is not a matter that is evidenced in the data nor developed in the paper. Finally, care workers were asked to specify their contract type and nine (seven of whom who worked for local authorities) were on permanent, guaranteed hours contracts and two on fixed term (not guaranteed hours) contracts with the remainder (30, 73 per cent) being on zero-hour contracts. This again reflects the national picture in Wales.

Again using the funder-provided contact database, the research team e-mailed invitations to commissioners in all 22 local authorities and in this way arranged seven telephone interviews. This gave 80 participants in total. Three Care and Social Services Inspectorate Wales-led (CSSIW) workshops that formed part of a domiciliary care review (CSSIW, 2016) were additionally attended. This added 33 participants, 17 commissioners and 16 service providers, giving 113 participants in total. All participants worked in domiciliary care, except one care worker based in learning disabilities, and breakdown by sector comprised: 8 local authority providers and 10 care workers; 15 private sector providers and 24 care workers; and 9 voluntary sector providers and 7 care workers. Around three quarters of each group were drawn from the independent sector, which reflects national patterns of care delivery. Project time constraints meant that it was not possible to gain ethical approval to interview care recipients, rather participants’ views were elicited as to what constituted good quality care.

The paper reports a subset of project data related to fragmented time. Full focus group schedules are available in the funder report (Atkinson *et al.*, 2016). All interviews/focus groups were recorded and fully transcribed. Detailed notes were taken and transcribed at the CSSIW workshops. Thematic data analysis (King, 2004) was undertaken, transcripts being subjected to close reading and excerpts coded that were relevant to fragmented time, recruitment and retention and care quality and their inter-relationships. Initially, each focus group transcript was analysed, then all service provider and care worker data were combined into two templates before the data and commissioner interview data were finally combined into one template. Relationships were inductively developed, integrating fragmented time, as per Rubery *et al.* (2015), with Francis and Netten’s (2004) dimensions of care quality (summarised in Table II). Throughout, detailed discussion took place to ensure consistency and shared researcher understanding. Data are presented by attaching commissioner, service provider and care worker labels and the focus group from which it was gathered is indicated.

Findings and discussion

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

Marketisation and fragmented time

While a detailed review of external commissioning practice is beyond the scope of this paper, the impact of marketization was apparent. Local authority practice created substantial instability for service providers as most commissioners operated framework agreements (Bessa *et al.*, 2013), coupled with widespread use of spot contracts (Knapp *et al.*, 2001) using time-based commissioning. All purchased the majority of care in short blocks of 30 min or less. All commissioners acknowledged the insecurity for service providers, as income flows were uncertain and would immediately cease on care recipient hospitalisation or death. Commissioners equally acknowledged funding constraints (Age Cymru, 2015) and some

argued that care had “unfortunately” become a business and local authorities were battling austerity and “there’s very little money out there to [fund care at an appropriate level] [...]” (Interview 1). Indeed, monopsony pressures suppressed rates (as per Cavendish, 2013) to around £14–15 per hour, below the UKHCA (2015b) calculated hourly cost of £16.70.

Commissioners recognised that low and insecure payments could negatively influence the employment practice of independent service providers (confirming Rubery and Urwin, 2011, Cunningham, 2008) but budget constraints dominated:

It’s a challenge, both for the sector [...] making sure they have got good [care] standards, but also for local authorities because to pay for that comes at a cost. With a shrinking budget. From a local authority perspective, I don’t think any of us would ever disagree that there should be appropriate terms and conditions and [care workers] should be paid the appropriate rate. But [...] [local authorities struggle to influence this]. (CSSIW Workshop 2)

No local authority regulated care worker employment terms and conditions via their framework agreements (as per Bessa *et al.*, 2013) and monitoring addressed only compliance with standard employment legislation. Some commissioners expressed a desire to integrate Unison’s Ethical Care Charter into future frameworks but, given funding constraints, this seemed a remote aspiration. Marketization thus had substantial implications which are starkly demonstrated in what follows, first in respect of fragmented time, where service providers transferred commissioning risk to care workers and relied almost exclusively upon zero-hour contract arrangements, operated episodic working practices and were constrained by commissioning in visit length, and second for care quality.

Zero-hour contracts

While local authority providers operated standard local government terms and conditions and offered guaranteed hours, in the independent sector zero-hour contracts were explicitly related to commissioning-led income insecurity (Burrowes, 2015):

There is not a lack of hours [for care workers] [...] but we can never guarantee them because of the [unstable] nature of the business. (Service Provider, Focus Group 2)

Two independent providers sought to reduce insecurity by offering (some) guaranteed-hour contracts, but this was problematic and one noted that “it’s very hard if they lose [care recipients], I end up giving them office work” (Focus Group 4). Care workers in the independent sector, where nearly all worked on zero-hour contracts, expressed insecurity and concern:

At the moment, we’ve got loads of hours but as soon as someone goes into hospital, we lose like four calls a day [...] then you get hardly anything for the week. (Care Worker, Focus Group 3)

You get the hours. Never, ever have I been without, but still it’s just like, what if? You feel like you don’t have a leg to stand on. (Care Worker, Focus Group 1)

Most care workers expressed a strong preference for guaranteed-hour contracts, although some, mainly mothers and students, welcomed the flexibility zero-hour contracts offered (Atkinson *et al.*, 2016).

Zero-hour contracts were strongly associated with difficulties in both recruitment and retention. Independent providers argued it was hard to attract workers into the sector when total flexibility in working time was demanded:

We are restricted because we expect total flexibility and that narrows down the [labour] market [...] when people come on board it’s a zero-hour contract [...]. It doesn’t always work in our favour [for recruitment]. (Service Provider, Focus Group 4)

Tellingly, most of the local authority care workers had previously worked in the independent sector and suggested that reducing insecurity had been central to their decision to move local

authority employment. Lack of guaranteed hours thus contributed to a highly transient workforce that moved around independent providers for often minor improvements in terms and conditions. Resulting labour shortages meant that care packages could remain uncommissioned for lengthy periods, leading to bed-blocking (Marsh, 2016), and creating a vicious circle of long working hours (Bessa *et al.*, 2013), resulting in stress and burnout (as per Taris *et al.*, 2003):

We expect a lot from them, they are very tired. Because there is a [shortage]. We are ten care workers down, 250 hours, which is a lot. (Service Provider, Focus Group 4)

Zero-hour contracts were thus implicated in labour shortages through both sickness absence and turnover (Rubery and Urwin, 2011). Use of the contracts confirms the insecurity aspect of Rubery *et al.*'s (2015) fragmented time index, and findings here also evidence other indexes, e.g. variable schedules due to staff providing additional cover.

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:

Trying to get staff to understand is really, really hard [...]. Our main [calls] are between half-six and half-nine in the morning, then lunchtime [...] and then tea to bedtime. But in between, there's nothing. So staff are like, "Well, I'm out for six hours and you've only given me three", but if there's only three hours and nothing in between [...]. (Service Provider Focus Group 3)

Most care workers were vocal in their dissatisfaction with episodic working, as non-payment for waiting time resulted in long hours and low earnings (as per Rubery *et al.*, 2015):

The most frustrating thing is [...] you're starting at eight in the morning [...] you make it home at ten at night, and if you tally up all the amount of hours that you get [paid for] [...] five hours [...]. (Care Worker Focus Group 4)

This was compounded by non-payment for travel time which, particularly in rural areas and for numerous short visits some distance apart, could account for a substantial proportion of a care worker's "run", or visit schedule (as per UKHCA, 2015a). Care workers were acutely aware of these pressures and resentful, arguing that they were often doing "fulltime work for part-time pay" (Care Worker Focus Group 1).

Episodic working in the independent sector thus created dissatisfaction with long, demanding working days that generated high levels of stress (as per Cooke and Bartram, 2015) and burnout (Taris *et al.*, 2003). Both sickness absence and labour turnover resulted (Rubery *et al.*, 2015) and an exodus to other low-paid sectors. Retail employment, for example, was seen as more attractive as, despite frequent use of zero-hour contracts, working time was not episodic and the work was not as stressful (confirming Broadbent, 2014; Brown and Korczynski, 2010).

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 sectors. Provider and care worker data evidence that the overwhelming majority of visits were 30 min 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 minute 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):

We expect a lot from them, they are very tired. Because there is a [shortage]. We are ten care workers down, 250 hours which is a lot. (Service Provider Focus Group 2)

When I ask them [existing care workers] to do more, like I've had to ask them to at the moment, that can create sickness [...]. (Service Provider Focus Group 3)

While most care workers experienced intrinsic job satisfaction derived from caring (Carr, 2014), this co-existed alongside extrinsic dissatisfaction (King *et al.*, 2013), particularly evident in respect of fragmented time. Independent providers all questioned the sustainability of current care models given the stress and burnout occasioned for care workers (Taris *et al.*, 2003) and the resulting sickness absence, labour turnover and labour shortages (Rubery *et al.*, 2015).

While local authority care workers were employed on better terms and conditions, they comprise a small proportion of domiciliary care workers in Wales (CCW, 2014) and nevertheless worked with primarily short visit times. For the majority, employed in the independent sector, commissioning practice structured an employment relationship dominated by fragmented time, resulting in recruitment and retention difficulties and consequent labour shortages. These structural conditions inform understanding of the care worker/recipient interactions that determine care quality.

Fragmented time and care quality

No one sets out to provide bad care, but you're dragged to it, dragged into the gutter. (Service Provider, CSSIW Focus Group 1)

This quote powerfully illustrates service provider concerns around marketisation processes that drive fragmented time and diminish care quality. These concerns were shared by care workers who argued that time was critical to effective care delivery:

You need time to do quality care. You do need the time. (Care worker Focus Group 3)

Indeed, lack of time was argued to be tantamount to abuse. More specifically, the detriment of fragmented time to care quality was evident against the dimensions of continuity, reliability and flexibility (Francis and Netten, 2004). This is summarised in Table II and supported below by rich participant narratives.

Table II.
The implications of
fragmented time for
care work and
care quality

Care workers and service providers			Continuity	Reliability	Flexibility
Zero-hour contracts	Care workers		Highly variable working patterns; substantial labour turnover	Highly variable working patterns; substantial labour turnover	Highly variable working patterns; limited access to training
	Instability		Outcome: many different care workers visit care recipient	Outcome: visits unfulfilled or care workers arrive late	Outcome: care workers lack both knowledge of care recipient and skills to deliver flexible care
Episodic working	Work intensification				
	Dissatisfaction				
	Stress and burnout				
Visit length	Service providers		Substantial labour turnover	Inadequate travel time and scheduling of concurrent visits	Inadequate time with care recipient
	Recruitment difficulties		Outcome: many different care workers visit care recipient	Outcome: care workers arrive late and call times are reduced	Outcome: care workers struggle to fulfil care plan and cannot go beyond it
	High labour turnover				
Sickness absence					
	Labour shortages				
Visit length			Inadequate time with care recipient	Inadequate time with care recipient	Inadequate time with care recipient
			Work intensification, stress and burnout, sickness absence	Work intensification, stress and sickness absence	Work intensification, stress and burnout, sickness absence
Visit length			Outcome: many different care workers visit care recipient	Outcome: care workers arrive late and call times are shortened	Outcome: disassociation creates reduced flexibility

Continuity, the consistency of care worker visiting a care recipient, was consistently cited as important and was explicitly required by all commissioners. Care workers also argued its importance in building relationships with care recipients when providing an intimate service (Eborall *et al.*, 2010) and expressed dissatisfaction when this was not possible. It underpinned high quality, relational care (Atkinson and Lucas, 2013):

Continuity is a big part [...] she has dementia, sometimes she just forgets to eat. It's little things like that we pick up on because we know her. Other carers will just put the food back in the fridge, they'll assume that she's eaten something earlier on in the day. It takes us who know her well to know that she's just forgotten to eat. (Care Worker Focus Group 2)

It's hard to build up that relationship with somebody, to have them naked in front of you so you can put them in the shower and [...] you've got that confidence and then they're moving you on now to somebody else. (Care Worker Focus Group 1)

Zero-hour contracts mitigated against continuity. First for care workers in creating unstable and changeable working patterns. Second for service providers, as care workers could and did refuse shifts offered. These contracts contributed to recruitment and retention difficulties:

[...] we've talked about zero-hours contracts and [their] issues [...] people move around, they don't want to stay in that job; that affects [continuity]. It's just like a big circle really. (Service Provider CSSIW Focus Group 3)

Episodic working practices also risked undermining care worker commitment to care delivery:

You've got to drive here, drive there [...] then you start considering the logistical impact, financially and think, what is the point? [...] that contradicts every reason you're here. Because you start getting a little bit disgruntled. (Care Worker Focus Group 4)

This fed both labour turnover and sickness absence through worker dissatisfaction, stress and burnout (as per Taris *et al.*, 2003). Continuity was thus compromised by both unstable working patterns and the resulting labour shortages, as independent providers struggled to resource provision from a highly transient workforce.

Reliability, arriving when scheduled and promptly, was central to positive care recipient experiences:

One of our clients is very time conscious, she won't let you in early, she won't let you in late, and that brings a stress then because [...] the constant conversation is, "I don't understand why you're late". (Care Worker Focus Group 2)

Zero-hour contracts and resulting labour shortages could, at the extreme, lead to non-fulfilment of scheduled care. More commonly, episodic working and insufficient (unpaid) travel time caused late arrival:

Travel times can be an issue [...] we'll have to go from X to X in five minutes, and you just can't do it. It's a fifteen minute trip [so we are] late and for the rest of the day we find ourselves constantly [...] catching up with the calls. (Care Worker Focus Group 1)

Short visits compounded these difficulties, as unrealistic time allocations occasioned delays and further reduced visit times. The work intensification and poor care that resulted for all was extremely stressful:

We do toileting, food and medication. To do all that in fifteen minutes and do it to the best of your ability, you need more time. (Care Worker Focus Group 4)

It is so wrong, but I've heard about times when care workers have had to feed people their lunch as they are on the commode. (Service Provider, CCSIW Focus Group 2)

Attempts to offset these pressures could result in substantially reduced care, by for example, concurrent scheduling of visits that created extra stress for care workers.

Care commitments were thus difficult to fulfil given labour shortages and high labour turnover. Care recipients experienced late or missed visits which reduced their capacity to retain control over their lives (Iparraguirre and 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 take fifteen minutes, and then you've still got to wash them, dress them, do the breakfast, make the bed, empty the commode. It becomes a fifteen-minute call because you've spent so long trying to reassure them that you're there to help them. (Care Worker Focus Group 2)

Visit length, as evidenced here, was frequently not adjusted for complexity of need (as per Rubery *et al.*, 2015) and so even 30 minute visits, the maximum length of most visits across local authority and independent sector providers, were insufficient to deliver good care. Care workers argued for longer visits that offered the flexibility for them to offer "proper" (flexible) care and promote the independence espoused by policy:

Doing personal care and things around the house for them is important, but [so is] actually sitting down and just knowing that I haven't got to rush off. (Care Worker Focus Group 4)

How can we be promoting independence, doing all the things that we want to be doing, if we're kept to a twenty minute call. It's impossible, it can't be done. (Care Worker Focus Group 2)

These time pressures were deeply problematic, creating stress and burnout for all care workers:

The last thing they want to feel is rushed, especially if you're a ninety-eight year old who gets a little bit breathless. The last thing he wants is, "Come on now, we've got to go, we've got to do meds now." And he's like, "Hang on a minute, I haven't had my tea yet". (Care Worker Focus Group 3)

Additionally, burnout could lead to disassociation which reduces flexibility still further (Taris *et al.*, 2003). The delivering of outcomes-based care, central to policy aspirations (e.g. Welsh Government, 2015), was compromised by lack of flexibility.

It should be noted that most care workers were deeply committed to domiciliary care and described leaving to work, for example, in retail, as "going over to the dark side". Job satisfaction was widely linked to the exercise of discretionary behaviour (Huang and Gamble, 2015) and there were repeated examples of care workers doing shopping or returning to offer care in their own time to ensure good care. Some service providers expressed concern over professional boundaries, but care workers argued that it was the only way to ensure good care. This effort was maintained despite dissatisfaction with fragmented time and created a hidden burden of stress and work intensification (Broadbent, 2014). Yet despite maintaining commitment to care recipients, many did not maintain commitment to service providers (Brown and Korczynski, 2010). Their dissatisfaction with constraints on quality care provision was the biggest factor in care workers leaving the employer, through both the time pressures that led to both poor care and stress and burnout:

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-hour 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 it generated 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, generating 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 quality. Despite these limitations, the paper evidences that fragmented time creates a dual burden for two vulnerable groups, the care workers who bear its hidden consequences (Brown and Korczynski, 2010), and the care recipients who experience reduced care quality.

Conclusions

This paper explores aspects of employment practice in domiciliary care work to ask: what are the consequences of fragmented time for care quality? It makes a valuable empirical addition to social care employment research, particularly in reporting care worker perspectives on this question. Drawing on Rubery's (2015) analysis of employment trends, it demonstrates that fragmentation and flexibilisation in a highly feminised sector combine to create fragmented time and that this is detrimental to care quality. Independent providers, who deliver around 80 per cent of domiciliary care, struggle to recruit and retain the necessary labour (Rubery and Urwin, 2011); care workers suffer dissatisfaction, stress and burnout (Taris *et al.*, 2003); and care quality is compromised through lack of continuity, reliability and flexibility. The research site is Wales, but similar international policy contexts mean the findings have wider resonance (e.g. Cunningham *et al.*, 2014; Broadbent, 2014).

The paper makes both empirical and theoretical contributions. Empirically, it confirms Rubery *et al.*'s (2015) findings that fragmented time creates care worker detriment. It confirms many of the indexes proposed for fragmented time, including (lack of) payment for work-related activities (e.g. travel) and fragmented/variable/extended schedules. While Rubery *et al.* (2015) noted the time-constrained nature of care work, they had insufficient data to include visit length in that index of fragmented time. Importantly then, this research provides evidence to extend its definition to include visit length, noted as important in other care settings (Bee *et al.*, 2008). Short visits were prevalent and substantially implicated in both work intensification and care worker stress and poor care for recipients. Rubery *et al.* (2015) demonstrated tensions arising from fragmented work allocation, i.e. zero-hour contracts and episodic working, but this paper evidences that its fragmented construction, i.e. short visit length, is equally problematic. Importantly, this applies not only to visits of 15 minutes or less, but equally to longer visits that are nevertheless insufficient to address complex care needs. The extended definition of fragmented time is critical to understanding the pressures that derive from both employer and care recipient demands and how these mutually reinforce to create pressure for workers (Taris *et al.*, 2003) and inferior care for recipients. Employers, particularly in the independent sector, also experience substantial pressure. They grapple with establishing an adequate workforce in the face of financial constraints arising from the commissioning monopsony of local authorities within marketised social care. These empirical and theoretical contributions advance research that has hinted at employment/care quality relationships (Broadbent, 2014; Cunningham, 2016) to evidence how particular features of the employment relationship are detrimental to care quality.

The findings also raise substantial policy concerns that dictate urgent review of commissioning mechanisms. It is questionable whether market approaches can deliver the employment practice needed for high-quality care (Rubery and Urwin, 2011). Local authority monopsony, both prior to and during austerity, has suppressed commissioning rates at potentially uneconomic levels and, coupled with widespread use of spot contracting and strict time-based commissioning, created the fragmented time practices evidenced here. While it is hardly novel to suggest that domiciliary care is inadequately funded, this paper evidences a clear pathway from commissioning practice to service provider and care worker struggles to poor care quality. This builds an incontrovertible body of evidence for policy makers that high-quality domiciliary care will not be delivered without more secure, better-funded commissioning that drives improved employment practice (Grimshaw *et al.*, 2015; Rubery *et al.*, 2013). Most domiciliary care is delivered in the independent sector creating, in many countries, a “race to the bottom” in employment (Cunningham, 2008). While voluntary frameworks exist, for example, Unison’s Ethical Care Charter, these are unlikely to suffice in creating the good work that will underpin high-quality care (Rubery and Urwin, 2011). Regulation may instead be needed.

As noted at the outset, demand for domiciliary care is growing as western populations age and the offer of good quality employment is fundamental to its effective delivery (Kingsmill, 2014). This exploration of fragmented time paints an alarming picture of tensions and pressures experienced by care workers and service providers. Inevitably, negative consequences ensue for care quality in a sector that both deals with one of society’s most vulnerable groups and underpins the effective functioning of health care systems.

Note

1. 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.

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