



“IT’S ALL ABOUT TIME”: TIME AS CONTESTED TERRAIN IN THE MANAGEMENT AND EXPERIENCE OF DOMICILIARY CARE WORK IN ENGLAND

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Drawing on a multilevel study of commissioning, employers, and care staff, this article explores the role of time in the management of domiciliary care work for older adults in England and the consequences for the employment conditions of care staff. An index of fragmented time practices among 52 independent-sector domiciliary care providers reveals widespread tendencies to use zero-hours contracts and limit paid hours to face-to-face contact time, leaving travel time and other work-related activities unpaid. Care staff interviews reveal how fragmented time creates insecurities and demands high work engagement. Time management practices are shown to derive directly from strict time-based local authority commissioning. Subcontractors, both independent small firms and those belonging to national chains, can at best adopt human resource (HR) policies that are partial routes to failure, as evident in widespread recruitment and retention problems. Informal HR practices to accommodate working-time preferences help to retain individual staff, but adjustments are often marginal, adversely affect other staff and fail to expand the recruitment pool for social care. Labor shortages are likely to persist as long as workers are required to adapt to a regime of fragmented time and to work more hours than are paid, even at pay rates close to the national minimum wage. © 2015 Wiley Periodicals, Inc.

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This article considers the role of time in the management of domiciliary care work for older adults in England and the consequences for the employment conditions of care staff. It makes two main arguments: first that human resource management (HRM) literature has paid insufficient attention to working time beyond the much debated work-life balance issues. This neglect applies particularly to fragmented time systems of employment organization, which may even require more commitment from staff than the full-time flexible hours typical of high-commitment management systems. The second argument is that the scope for real managerial choice or strategy with respect to human resource (HR) policies may be limited, particularly in sectors characterized by small

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establishments, low wages, and subcontracting relations with dominant clients. The conditions of operating in their particular environments may restrict the choice over management practices to alternative ways of muddling through—or as Hyman (1987) put it, alternative routes to “partial failure.”

These arguments are developed through a study of working-time practices in independent-sector domiciliary care providers (IDPs) in England. These are the key employing organizations for domiciliary social care in England; although domiciliary care is still mainly publicly commissioned and funded by local authorities (LAs), it is primarily undertaken by independent-sector providers, which provide 89 percent of domiciliary care hours (UK Home Care Association [UKHCA], 2013).

Although the significant variations in the organization of social care found in comparative research (Simonazzi, 2009) may influence the form and significance of working time issues, the key problem of how to deliver timely social care is common to all systems. Moreover, pressures are likely to move arrangements in developed economies closer to the UK model; for example, where care is currently provided by the family, there is pressure for more publicly funded provision, and where care is provided by public-sector employees, there is pressure to reduce costs through outsourcing. The tensions revealed in the English case around the organization of time may thus have wider relevance for developed economies as they all grapple with providing social care

to the increasing elderly population living in their own homes.

To explore these working-time issues, we define a fragmented time employment arrangement as when employers use strict work scheduling to focus paid work hours at high demand (sometimes limited to actual face-to-face engagements in in-person services) and do not reward or recognize work-related time between periods of high or direct customer demand. This shifts the risks of changing customer demand onto staff, increases work intensity in each paid working hour and blurs the boundaries between employee and self-employed status (Supiot, 2001). However, unlike the self-employed, care workers do not normally find their own clients or negotiate their own fees. Although much fragmented-time work is part-time (Blyton, 2011; Blyton & Jenkins, 2012), not all part-time work is organized this way.

Two interlinked sets of research questions are explored. First, to what extent does fragmented time characterize the IDPs’ employment practices and how does this affect care workers’ pay and working-time arrangements? Second, to what extent are HR policies—both formal and informal—used to compensate for fragmented time to secure an adequate labor supply? And if labor supply problems persist, why are other HR solutions not adopted?

The first section reviews the literature on the scope of HR strategy in sectors characterized by small workplaces and subcontract relations and on time management in service sectors such as care. This is followed by a presentation of the research methods adopted. The empirical findings are presented in two parts: the first explores the extent of fragmented-time systems in IDPs and the implications for working conditions; the second explores the use of formal or informal HR policies to resolve recruitment and retention issues in a context of fragmented-time policies and commissioning constraints. The final discussion considers the implications of the findings for understanding the role and scope for HRM policies in constrained environments.

Sectoral and Organizational Conditions and the Strategic Space for HR Strategy

It is generally agreed (Bacon, Ackers, Storey, & Coates, 1996; Cassell, Nadin, Gray, & Clegg, 2002; Harney & Dundon, 2006; Hayton, 2003; Wilkinson, 1999) that HR research has focused on large establishment firms with strong product market power and neglected employment areas characterized by low wages, small workplace size, or subcontracting relations. The independent sector for adult social care in England fits each of

these neglected characteristics. Not only are most care workers paid close to the minimum wage, but they are also employed in private-sector organizations that rely primarily on subcontract work from local government (Bessa, Forde, Moore, & Stuart, 2013). In 2013 there were over 9,000 organizations and over 18,000 establishments in nonresidential social care, and fewer than 5 percent of organizations had more than 100 employees (Skills for Care, 2014). National chains have increased in importance, particularly among the providers designated as preferred providers by LAs (Rubery, Grimshaw, & Hebson, 2013), but these tend to decentralize their HR practices to the discretion of local branch managers to allow for adjustment to commissioning practices of local authorities.¹

One reason for neglect is the frequent assumption in HR literature—exemplified by Lepak and Snell's (1999) human resource architecture—that activities outsourced are routinized and simple, requiring limited strategic HR attention. This characterization does not fit domiciliary social care where the work is demanding, and staff operate with high levels of autonomy and have to manage their work and family commitments over complex, extended, and fragmented work schedules. High-commitment work arrangements rely on self-discipline and internalized motivations to work (see Casperz, 2006, for a review) to ensure that employees work whenever and for as long as required. The rare studies that have investigated working time in high-commitment work systems (e.g., White, Hill, McGovern, Mills, & Smeaton, 2003) confirm that these involve long and unsocial hours that conflict with domestic commitments. However, the implicit assumption in the literature is that where high work commitment is required, an employer would be able to provide an HR package to compensate.

The small but growing literature on HRM in small firms and establishments in low-wage segments recognizes that this strategic space may be lacking. Limited managerial capacity and a constrained external environment reduce the scope for policies to protect and develop internal resources as anticipated in the dominant resource-based view of the firm that underpins high-performance management debates. The debate on HR in small firms and establishments has emphasized the influence of the external environment (Arthur & Hendry, 1990; Barrett & Rainnie, 2002; Harney & Dundon, 2006), which may act as a coercive network (in Bacon & Hoque's [2005] terms). These coercive pressures may operate primarily through the demands of clients, but while some clients may pressurize subcontractors to adopt positive, formalized HR policies, others, as in social care,

may deter positive HR diffusion by imposing cost constraints (Barrett & Rainnie, 2002; Rainnie, 1989). Where the consequences are poor employment conditions and high turnover, the implementation of other HR policies such as training may become more difficult. In adult social care the external environment has both induced and constrained diffusion of HR practices. For example, Cunningham (2008) finds that commissioning is requiring not-for-profit providers to meet HR standards without relaxing cost constraints, thereby intensifying pressures on management. Likewise, Gospel and Lewis (2011) found that the external environment had promoted internal training but without positive impacts on other HR strategies.

Another issue is the effectiveness of forms of HRM in different organizational and sectoral environments. Although research in both Australia (Harley, Allen, & Sargent, 2007) and England (Atkinson & Lucas, 2013) has found formal HR practices to have positive impacts on care workers' attitudes and performance, in many small firms and establishments the application of formal HR policies is often piecemeal, operating alongside more informal practices and not indicative of any consistent strategy (Cassell et al., 2002). The absence of a consistent formal HR approach is not necessarily viewed as negative, as informal practices may contribute to the high job satisfaction among employees in small firms and establishments (Storey, Saridakis, Sen-Gupta, Edwards, & Blackburn, 2010). In relation to adult social care, Atkinson and Lucas (2013) stress the informal adjustment of conditions, including working-time arrangements, in explaining care workers' positive attitudes. For others, informality brings some negative effects, including arbitrary decisions (Edwards & Ram, 2006), barriers to strategic development (Barrett & Claydon, 2010; Mayson & Barrett, 2006), and the likelihood of inconsistent messages (Casperz, 2006).

A more holistic understanding of the scope for using HR policies to recruit and retain care staff is provided by applying Hyman's (1987) analysis of the tensions between strategy versus structure. Management may be neither able nor even necessarily aiming to resolve the inherent contradictions between their external constraints and internal objectives, particularly where scope to reshape the external environment is limited. Instead, it may choose between options, none

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of which are likely to meet their goals but offer a way of getting by in the short term. For Hyman, “there is no ‘one best way’ of managing these contradictions, only different routes to partial failure” (1987, p. 30). From this perspective HR’s primary role is to offer marginal improvements within a context that is largely unalterable—shaped by structural constraints and business objectives.

Moreover, Fleetwood (2007) makes the argument that HR managers’ increased interest in offering marginal adjustments to working time in the name of work-life balance serves to deflect attention from the increasing flexibility demands on employees in general. In social care, marginal scheduling adjustments by managers for retention may be interpreted positively by employ-

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ees and possibly even considered a work-life balance policy but from a starting point of highly fragmented and unsocial working-time arrangements. The characterization of HR policy among social care providers by Atkinson and Lucas (2013) as focused on employee needs may thus be overstated, particularly if service delivery requirements remain unchanged and informal adjustment for one individual may heighten pressures on others:

This [hours] flexibility was valued by [care workers] and derived from workplace climate, where close personal relationships focused HR practice on meeting employee needs. (Atkinson & Lucas, 2013, p. 304)

One strategy for employers operating in constrained environments may be to mobilize a labor supply that either also faces constrained options or is particularly

attracted to the type of work. A number of studies have suggested that care work attracts those with altruistic motives (Mittal, Rosen, & Leana, 2009; Rakovski & Price-Glynn, 2010). If altruism were sufficiently widespread, employers would be able to secure an adequate labor supply without positive HR policies. However, care workers’ apparent altruism may not be related to personality attributes but develops through their actual performance of care work, which then entraps them in the sector (England & Folbre, 2003). This second approach is also compatible with the view that it is more the association of care with women’s work (Palmer & Eveline, 2012) and the limited intrinsically rewarding employment opportunities for

low-educated women that generates a supply of labor, although not necessarily an adequate supply (Hebson, Rubery and Grimshaw, forthcoming).

Working-Time Policy in Adult Domiciliary Care in England

The comment by a domiciliary care worker in our study that “it’s all about time” encapsulates the central importance of time in the management and employment arrangements in domiciliary care. Time is the key unit of account and, thus, a contested factor due to its role in shaping the distribution of resources. Time is also predominant in shaping the employment relationship due to the extended and fragmented working-time schedules.

Time is a particularly salient factor in in-person services, as these are coproduced with clients or users in real time. Time affects the quality and cost of service provision, the skills deployed, and the scheduling of work. In social care, if the user is not actively engaged with the carer in a trusting relationship, the particular needs of the user may not be identified (Aronson & Neysmith, 1996; Needham, 2009). However, while in consumer-oriented services, customers’ needs have to be balanced against production costs (Batt, 2007; Korczynski, 2002), users of social care are less able to exert pressure on providers. This is both because in England it is LAs that commission and fund the service directly so that user satisfaction is not critical for repeat business and because elderly adults are often frail and not best able to voice concerns.

In social care, the triangular relationships in direct personal services (Leidner, 1993) among employees, consumers or users, and employers becomes four-way, with the LA acting as the dominant client (Fudge, 2006; Marchington, Grimshaw, Rubery & Willmott, 2005). In practice, the LA, by setting the fee per hour of care and determining each user’s care package measured in specific blocks of time and scheduled in specific time periods, allows the direct employer limited scope to shape pay and working-time conditions. The dominance of the LA client may obscure the responsibilities for the actual employment relationships within social care. Although staff are directly employed by IDPs, they may regard the LA as responsible for shaping these conditions, particularly if their own employer frequently reminds them of this influence.

Within this system, time is the key control mechanism, as it is used as a proxy for service delivery to users, for commissioning by LAs, for fee invoicing by IDPs, and for care staff’s pay entitlements. By serving as the unit of account, it

represents a claim on resources, which is thereby contested. This contestation arises first between the user's service needs and the costs of service provision. In LAs in England, time acts as a proxy for volume and quality of services, as the service price is often not adjusted to reflect quality or complexity of care or time of delivery (Bessa et al., 2013). Night work premiums are the only common additional fee paid. The flat fee carries the implicit presumption that care staff will not be rewarded for unsocial hours or for developing skills to provide higher-quality or complex care as the employer normally receives no compensatory fee enhancements.

A second area of contestation is the recording of time units. Recorded time may be an inadequate representation of actual service delivery, costs of provision, or the time spent in work-related activities. The intensity of the use of time as the unit of account is increasing with the adoption of electronic monitoring of care visits. In the absence of technologies to increase productivity in care, technology is being deployed to monitor care time, primarily to control resource flows for LAs. Commissioning of short care visits combined with electronic monitoring may shape the distribution of resources between LA commissioners and providers and between providers and care staff, but the actual deployment of care workers' time in caring activities often differs from formal recorded time. Care staff may provide more time than what is commissioned and paid for if they are reluctant to leave care tasks incomplete and finish them in their own unpaid time (Aronson & Neysmith, 1996; Baines, 2004). Care time may be less than commissioned time if staff perform a task faster than specified or if the user's family unexpectedly and voluntarily takes on some care tasks. This may cause staff to lose earnings, as electronic monitoring requires them to spend the commissioned time at the user's home.

The distillation of care delivery to a simple count of face-to-face contact minutes also exacerbates the productivity dilemma identified by Baumol (1993) that in-person services such as social care are unable to keep up with average productivity growth in the economy. In this case, any productivity increase through working smarter may reduce both pay for the care worker and fees for the provider, with all the gain captured by the commissioners. In addition, any improvements in quality of care may not be measured or captured within the resource model. Thus, shifts toward more complex care or better carers would not be recognized in the value-added attributed to the sector unless this resulted in a change in the service price. Options of moving up market

or introducing higher-performance work systems to resolve recruitment and retention problems or improve service quality may be precluded, as these may not enable providers to escape the low and flat value-added trap in domiciliary care.

The use of time as the unit of account interacts with problems of scheduling service delivery and translating this scheduling into work rotas and pay for care staff. These two interdependent factors—service scheduling and time as the unit of account—frame the job offer that IDPs can make to recruit and retain staff. These time-related factors, we argue, come to dominate the employment offer even where the need for work commitment is high and recruitment and retention problems persist. For both users and care staff, a key issue is how the scheduling of service delivery interfaces with their daily lives and personal commitments. Scheduling is further complicated by objectives to promote continuity of user or care worker relationships, which enhances the quality of care (Francis & Netten, 2004) and the quality of the care staff's work experience.

User needs in social care follow an hourglass pattern—high in the early mornings and evenings, with some demand at lunchtime, but thin for most of the standard working and school day. Weekend needs are also often as strong as weekdays. Care services are demanded exactly when care staff's personal and family care demands are highest and also extend into conventional personal and family weekend time.

Scheduling to fully meet user preferences is not possible. Meeting all users' preferences, for example, for care around 8 a.m., would require an enormous workforce and generate work rounds so short or so fragmented that many would not consider employment worthwhile. Time scheduling combines with time-related pay to shape the employment offer that may attract or deter, retain or dispel recruits and, thus, the ability to meet service user needs, including continuity of care. It is in this context that IDPs have to develop their HR policies to enable them to staff their services and provide an acceptable continuity and quality of care for individual users. However, IDPs may also seek to avoid costs associated with social reproduction of labor; this includes the costs of travel and the time spent traveling to the workplace and the costs of work-related activities such as time spent

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waiting to work, which cannot be used effectively for other activities or for other employers. This applies especially when these costs are not directly covered by commissioning arrangements.

Research Methods

To explore our research questions, this article draws on the second and third stages of a three-year (2007–2010) Department of Health research project into the recruitment and retention of a social care workforce for older adults in England. Only results in relation to domiciliary care are presented, although the project also covered residential care, as it is in domiciliary care that the issues of fragmented time occur. The starting hypothesis was that recruitment and retention are influenced by providers' HR practices, which in turn are shaped by commissioning policies.

The chosen research methods for the second stage combined a case survey (Yin, 1981) of commissioning practices in 14 LAs and a telephone survey of 115 of their social care providers, including 52 IDPs. The third stage involved 20 in-depth case studies of providers selected from the telephone survey respondents in four of the 14 LAs, including eight IDPs, two from each LA, to explore workers' experiences of HR practices and their personal motivations for entering and staying in care work.

Both the second- and the third-stage results were drawn upon to explore our key research questions, namely, (1) the extent to which IDPs use fragmented time and the impact of fragmented time on pay and working-time conditions; and (2) the extent to which IDPs use HR policies, both formal and informal, to compensate for fragmented time to secure an adequate labor supply—and if not and labor supply problems persist, why other HR solutions were not adopted. We draw on the face-to-face interviews with the commissioners and the telephone interviews with providers to explore the factors shaping the use of fragmented time and use the interviews with care staff to provide supporting indications of its impact on actual working conditions. The exploration of the role of HR policies in mitigating these effects draws primarily on the telephone survey, but most direct quotations from providers are drawn from the eight case-study IDPs.² The interviews with care staff are also used to provide illustrative examples of how IDPs managed working-time and associated HR policies in practice; worker experiences and their motivations for entering and staying in care work are explored in the main report and other publications (Hebson, Rubery & Grimshaw, forthcoming; Rubery et al., 2011).

The sampling strategies and main lines of analysis of the data collected at the different stages can be summarized as follows. Theoretical sampling motivated the selection of the 14 English LAs. A cluster analysis of 92 responses (out of a population of 149 LAs) to a postal survey of commissioning practices for older adults' services in the first project stage (Hughes, Chester, & Challis, 2009) based on three dimensions of commissioning—namely, the degree of integration with health commissioning, the emphasis on employment issues in contracts and tenders, and the extent of flexible delivery for users—yielded seven clusters of commissioning types. Two LAs were selected from each cluster (except that three were taken from the largest and one from the smallest). Semistructured interviews, lasting two hours on average, were held at each LA with the person with prime responsibility for commissioning older adults' social care. Follow-up telephone interviews were held in five LAs, and in six LAs the initial interview was with multiple participants. A total of 34 people were interviewed. A telephone survey was then conducted among the population of older-adult care providers in the 14 LAs, yielding a sample of 105 IDPs (17 not-for-profit, 88 private providers; 53 residential homes, 52 domiciliary care providers) and 10 LA domiciliary care providers. The interviews lasted around 45 minutes and covered six areas: recruitment and retention, pay and working time, performance management, training, relationships with LAs, and attitudes toward care standards and public policy. The analysis of the 14 LAs found that although there were marked differences in attitudes to commissioning that we classified along a spectrum from partnership to cost minimizing (see Rubery et al., 2013, for details), these differences in approach were constrained by a common framework. This included: repeat tendering (precluding long-term partnership); highly constrained fee levels (with fees varying only between £10.45 and £14.50 per hour with one exception that paid more generously); and an increasing tendency for all LAs not to pay extra for more skilled work, for unsocial hours, for travel times (except for rural communities), for short visits, or for continuity of care for short-term hospitalization. These latter factors had the most impact on fragmented working time, so that differences among LAs in commissioning approaches do not appear as an important factor in the current analyses of working-time practices.

The telephone survey adopted quota sampling to include three to four residential homes and three to four IDPs per LA. For domiciliary care, those agencies with preferred or block provider

status were sampled first. The outcome of focusing on the major providers was that 31 of the 52 IDPs belonged to national chains and 21 to local organizations—10 of which had more than one establishment but only operated in either just one LA or in immediately neighboring LAs. It was anticipated that these differences in ownership structure would have an impact on HR policies and outcomes, but extensive analysis revealed only small differences by ownership (Grimshaw, Rubery, & Ugarte, forthcoming; Rubery et al., 2011), and thus, for the purposes of this article, the results from the different types of IDPs have for the most part been combined. Only 14 of the 52 IDP establishments had more than 100 employees even on a head-count basis, and again extensive analysis found no significant differences in HR policies or outcomes by establishment size. Due to the increasing importance of national chains in the elderly care sector in England, we undertook telephone interviews with 10 national chains at headquarter level, five in domiciliary care.

Eight case studies of IDPs were conducted in four LAs that spanned the whole commissioning spectrum from partnership to cost minimizing and from the highest to the lowest fee levels, with two positioned fairly evenly in between. The LAs also included two from the north of England and two from the south, covering wealthy and poor areas. We conducted 41 face-to-face interviews with care staff in the eight IDP case-study organizations, including 35 women and six men. Eleven had some care coordination or supervisory roles. In each case study, the sample included new recruits and longer stayers, to tease out the different experiences and orientations toward the work.

Fragmented Time in Adult Social Care

A high use of fragmented time practices by IDPs can be anticipated due to the time-based commissioning practices found in all 14 surveyed LAs. All either paid a uniform hourly fee or paid a fee according to the provider's tender offer, but the fee did not normally increase for complexity of care or for unsocial hours, except for night work. The LAs justified their increasing use of a flat fee by the saving in transaction costs. The LAs all commissioned services in time units, with minimum visits varying from 15 to 30 minutes. Half of the LAs used electronic monitoring of face-to-face care time for at least some providers and a further three were planning its introduction. None paid for working time outside face-to-face contact time, for training or for administration, and only one explicitly paid for travel time between users, although some paid higher fees in rural areas.

Most discontinued payments for home care when users were in respite care or hospital. Most hourly fees provided only a low margin above the minimum wage (from 82 percent to 153 percent above the national minimum wage [NMW] for 13 LAs at the median fee level, although one LA exceptionally paid a median-level fee 249 percent above the NMW), but LA commissioners insisted it was up to IDPs to determine the employment conditions on offer. One main way that commissioners had nevertheless sought to reduce risks of underpayment was to use only one or two providers per geographical area to limit travel times, but government policy to offer users in England more choice over providers was putting this arrangement in jeopardy.

This pattern of commissioning is strongly reflected in the IDPs' employment arrangements. Table I summarizes the extent of fragmented time systems used by IDPs by constructing an overall index. The index is the unweighted average of six subindices, which are constructed from a total of 19 indicators. For each indicator, subindex, and the aggregate index, the maximum score of 1 corresponds to a notion of standard or good employment practice, from an employee perspective, and the minimum score of zero corresponds to poor practice: 14 of the 19 indicators listed in Table I are constructed to generate a low (0), medium (.5), or high score (1), while four are binary and one is a four-level indicator.³ The gap between the average score and 1, therefore, indicates the gap between actual practice and standard or good practice, from an employee perspective. The average index of fragmented time for all 52 IDPs is .50, which we interpret as suggesting that IDP employers are implementing working-time practices at only half the standard associated with good employment conditions for employees.

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TABLE I Fragmented Time Index for 52 Independent Domiciliary Care Providers

	Description of scores			% IDPs			Average value
	Low (0)	Medium (0.5)	High (1)	Low	Medium	High	
Aggregate index^a							0.50
1. Payment for time in work-related activities							0.51
1.1. Paid travel time/costs ^b	Not paid	Mileage or other costs	Pay supplement	44%	37%	19%	0.38
1.2. Paid breaks ^c	Not paid	n.a.	Paid	88%	0%	12%	0.12
1.3. Paid time for induction training ^b	Not paid	Partly or reimbursed later	Paid	27%	4%	69%	0.71
1.4. Paid training time	Not paid	Some courses	All paid	10%	13%	77%	0.84
2. Insecurity in volume of work							0.22
2.1 Zero hours contracts	All zero hours	Mix	All guaranteed hours	69%	17%	13%	0.22
3. Fragmented/variable schedules							0.27
3.1. Minimum work period ^e	No minimum	One hour or less	More than one hour	71%	17%	12%	0.20
3.2. Reliance on own staff for cover	Only own staff	Own staff plus external staff/agencies	Only external staff/agencies	90%	8%	2%	0.06
3.3. Tolerance of working longer unscheduled hours	Yes	Occasionally	Never	8%	75%	17%	0.55
4. Extended schedules							0.55
4.1. Maximum number of days ^b	7 days	6 days	5 or fewer	27%	52%	21%	0.47
4.2. Percent regularly working weekends ^d	100%	n.a.	<100%	62%	0%	38%	0.38
4.3. Available for weekends as recruitment requirement ^c	Yes	n.a.	No	65%	0%	35%	0.35
4.4. Working alone at night	Yes	Occasionally	Never	12%	25%	63%	0.76
4.5. Time off from caring for training	No	Sometimes	Yes	6%	8%	87%	0.90
4.6. Premiums for unsocial hours (weekends/night/overtime) ^b	None	1 out of 3 (0.33); 2 out of 3 (0.67)	All	13%	46%	33%	0.45
5. Time constrained work							0.78
5.1. Time to carry out work to high standard	No	To some extent	Yes	0%	29%	71%	0.88
5.2. Opportunities to develop good relationships	No	To some extent	Yes	21%	14%	64%	0.77
5.3. Electronic monitoring ^b	Yes	n.a.	No	29%	0%	71%	0.69
6. Work schedules to meet staff preferences							0.70
6.1. Schedules fit preferences	Occasionally	Most of the time	All of the time	4%	75%	21%	0.63
6.2. Importance attached to matching preferences	Unimportant or neutral	Important	Very important	11%	21%	68%	0.77

Note: a. Unweighted average of six subindices; b. 1 missing value; c. 2 missing values; d. 3 missing values; e. 7 missing values.

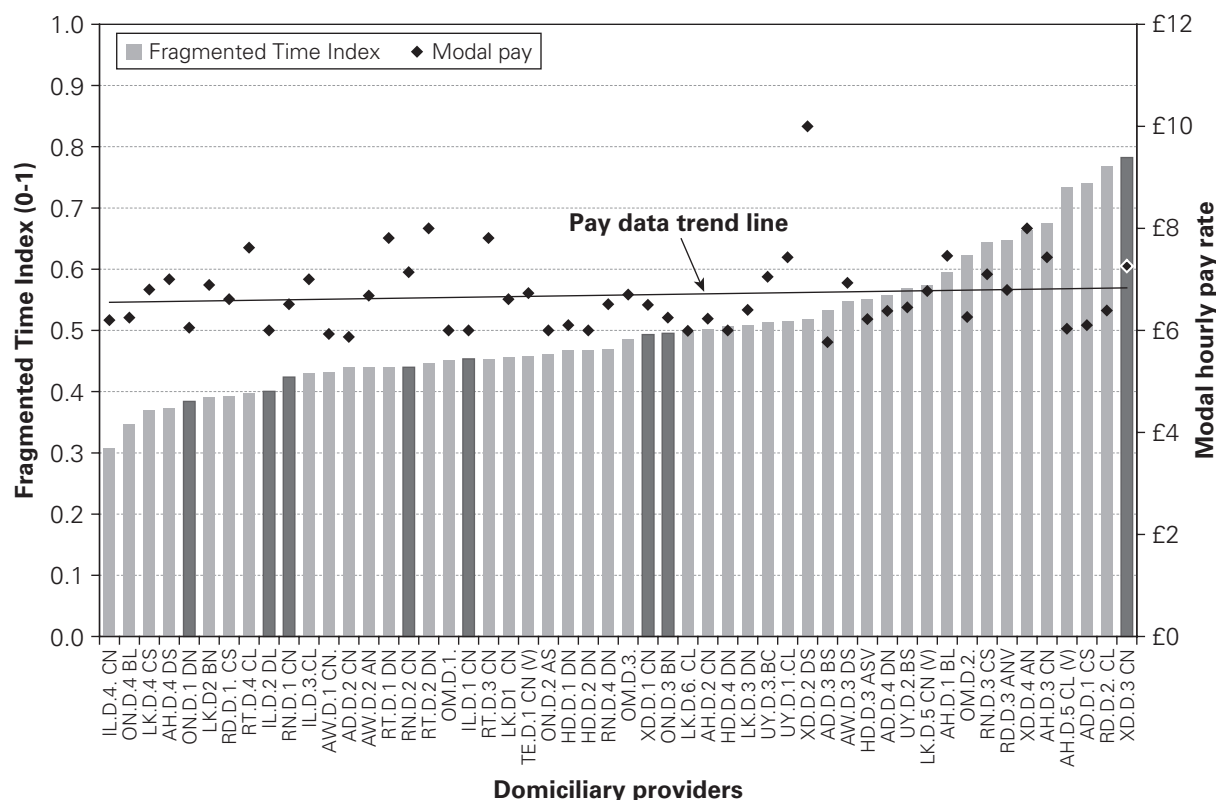


FIGURE 1. Fragmented Time Index and Modal Pay Rate for 52 Independent Domiciliary Care Providers

Note: Providers in black are the case study organizations.

the case-study organizations are placed within this spectrum.

The six subindices relate to different dimensions of fragmented time practices. The first sub-index, averaging .51 across the 52 IDPs, measures payment for time spent in work-related activities. The results show a high rate of non- or underpayment for time spent in activities such as waiting to work or travel between visits. Only 12 percent of IDPs paid for breaks between users, and only one in five paid a supplement for travel time, with a further 37 percent reimbursing some travel costs in the form of mileage allowances, petrol money, or public transport costs. Payment for time spent in induction or training is more common, but a significant minority still do not pay for all training time (Table I). These widespread practices of nonpayment were a source of significant discontent, as this care worker comments:

I spend a lot of time walking to everyone ... like yesterday ... I was out yesterday for six hours but I'm only getting paid for three hours of work. (RN.Dom 2 Care Worker 4)

The second subindex relates to guaranteed volume of hours: just 13 percent of IDPs offer

guaranteed hours, compared to the 69 percent that offer only zero-hours contracts. The remainder provide a mix, but guaranteed hours were often reserved for TUPE transferred staff⁴ or for car drivers. As such, this subindex is very low, an average of just .22. Many zero-hours staff regularly work long hours, but the contract enabled management to pass on the risk of loss of fees if users moved into respite care.

Management also used the lack of any guaranteed hours to increase staff compliance with a changing mix of users and rotas: “people who are not flexible, they don’t get so many hours” (Manager TE.Dom 1). Care workers were very aware of these risks:

I’ve been doing six and seven days a week with her. ... So when she goes [into a home] that’s twenty hours that I will lose. (RN.Dom 2, Care Worker 2)

The third subindex, again with a very low score of just .27, captures fragmentation and variation in work schedules. Almost three in four IDPs had no minimum work period, and 17 percent had a minimum of one hour or less. Also, only 10 percent used any external staff or agencies to cover for absences, so staff were often pressured to

work additional hours at short notice. This practice takes on importance because under a zero-hours system each new work package has to be separately allocated rather than covered by staff on a continuous shift.

They're always ringing you up asking you to do extras all the time. ... When they keep mithering⁵ you, asking you to do this, do that, ringing you, you know. (ON.Dom 1, Care Worker 1)

The fourth subindex relates to extended work schedules, which arise because of the pressures to work extended schedules, whether to cover staff shortages or for financial reasons (due to low pay).

Three indicators relate to days worked: one in four

Extended schedules mean working at unsocial times and extra hours after work, and frequently over more than five days a week, yet 27 percent of IDPs paid no weekend premium, 67 percent paid no night premium, and 29 percent no overtime premium.

IDPs had maximum working weeks of seven days; almost two-thirds had all their staff regularly working weekends; and two-thirds included willingness to work weekends as an essential recruitment requirement. The resulting working-time patterns are complex and for many care staff mean involvement in work over most waking hours for at least part of the week. Most providers use a range of shifts that includes split shifts. Examples of extended working schedules include:

Well, I normally work Tuesday 8 o'clock in the morning till 12, then I have a break for about three hours, then I'm back out three till half ten. But the three till half ten I have an hour-and-a-half break in between that as well. And that's Tuesday, Friday, and Saturday. I start at half seven and finish at half ten.

And Wednesday is 8 till 12 o'clock. (IL.Dom 1, Care Worker 1)

Twelve days on and two days off. I do eight till two and the four till ten. (IL.Dom 2, Care Worker 3)

These fragmented and extended working-time schedules often require staff to engage with work and work discipline over a high share of their waking hours; they spend much of the day traveling to and from work and waiting to resume work such that their free time is fitted between work periods, requiring extensive management of the boundaries between work and home commitments. Extended working may not always be safe, as more than a third of IDP employers expect staff

to work alone at night often or occasionally (Table I). Extended schedules mean working at unsocial times and extra hours after work, and frequently over more than five days a week, yet 27 percent of IDPs paid no weekend premium, 67 percent paid no night premium, and 29 percent no overtime premium.⁶ Even when premiums were paid, these were often a matter of pence per hour. Dissatisfaction was widespread.

And I think it's terrible that you go out after six and you still get paid the same amount as if you were going out to do a lunch call. (RN.Dom 1 Care Coordinator and Care Worker)

Overall, the extended work subindex records a score of .55, but given the low premiums generally paid this may be a too generous assessment.

The fifth subindex captures the time constraints on the work itself, caused in part by LA commissioning practice. Almost one-third of IDPs were already using electronic monitoring. A further aspect, omitted from the index due to missing data, is the length of minimum visit times; two-thirds of our usable sample set a minimum of 15 minutes or less.⁷

This subindex also captures two subjective indicators based on whether managers considered care staff had time to carry out work to a high standard or had opportunities to develop good relations with users. Managers held relatively positive views with respect to the time constraints their staff worked under, but interviews with care workers suggest that the questionnaire data provide too rosy a picture. Electronic monitoring was increasing, and for staff to maintain good relations with users, this often required them to use their own unpaid time.

Sometimes you go over into your time, and you end up giving your time. I don't rush them, I don't panic them, I don't make them flustered, I just take my time and do what I have got to do. (IL.Dom 2 Senior Care Worker 1)

The reliance on the goodwill of care staff not only to create good relations but also to ensure the safety of the user without any compensation is clearly indicated by this example from a care coordinator:

The council have told us that they've pretty much run out of money. ... For example, we have a client who is a double up one hour in a morning,⁸ ... it's taking the carers an hour and a quarter because they can't leave her without care

... and they ask us, "Why are you not paying me for this time I have to spend with this client?" And we don't have an answer. We as a company, as a business, cannot pay them for that time, but the council can't agree it, and we can't leave someone without care. (RN.Dom 2, Care Coordinator)

Thus, the employees are left to bear the costs even though time spent at work is and continues to be core to legal employment obligations.

The sixth subindex relates to the views expressed by management on the extent to which they were able to match working schedules to employee preferences and the importance they attached to matching employee preferences. Managers were mainly positive about their ability to match employee preferences, although

three-quarters said this applied only most of the time (Table I), and, for the most part, attached high importance to so doing. As we discuss below, the high score of this subindex (.70) perhaps indicates that the adjustment to employee preferences is undertaken from a starting point of expectations of high fragmented-time practices.

Reconciling the Irreconcilable through HR Policies

The fragmented time index reveals a very high use of fragmented time practices across the sample of 52 IDPs. Unsurprisingly, therefore, the IDPs frequently faced problems of resourcing and sustaining an adequate labor supply. Table II provides a range of indicators drawn from the telephone survey, which suggest that many providers were facing significant difficulties in recruiting and

TABLE II Indicators of Recruitment and Retention Difficulties among 52 Independent Domiciliary Care Providers and Correlation with the Fragmented Time Index

Indicators of recruitment and retention:	% of IDPs		Correlation with fragmented time index	Sample size
	Poor experience	Better experience		
Staff turnover:				
Turnover	30% with turnover 50%+; 19% with turnover 20%-49%	51% with turnover <20%	-0.213	37
Retention of new recruits	32% retained less than half	68% more than half (22% all)	0.297*	37
Staff shortage:				
For weekend or unsocial hours	69% shortage	31% not a shortage	0.165	52
For night work	37% shortage	63% (not all may need night work)	n.a	n.a
Recruitment problems:				
Knowingly hire staff without all the desirable attributes	33% occasionally; 17% often	50% never or almost never	0.032	52
Sometimes put up with poor performance due to recruitment problems	43%	57%	0.272*	51
Reject suitable applicants	77% never or almost never reject	23% very often, often, or occasionally reject	-0.011	52
Ease of recruiting care workers	39% quite or very difficult; 20% neither easy nor difficult	41% quite or very easy	-0.036	51
Meet 50% NVQ level 2 training target	35% not met (two thirds of these blame staff turnover)	65% met	0.114	51

Note: Pearson correlation measure is significant (2-tailed) at the 0.1 level (*) and the 0.05 level (**).

retaining staff even after the onset of the 2008–2009 recession when the survey took place. This evidence includes:

- A high rate of staff turnover—31 percent on average—and significant problems retaining new recruits experienced in some organizations (one-third retained less than half the staff recruited in the past year).
- High staff shortage reported—around three-quarters having a shortage, nearly 70 percent for weekend or unsocial hours work.
- Half of IDPs often or occasionally recruited staff without all the desirable attributes, and 43 percent sometimes put up with poor performance due to recruitment problems.
- Three in four IDPs almost never or never turned down applicants with appropriate attributes.

<hr/> <p><i>In view of these widely perceived problems of labor supply, one might expect IDPs to develop other HR policies to compensate for the negative aspects of the fragmented-time systems.</i></p> <hr/>	<ul style="list-style-type: none"> • Almost 40 percent found recruitment quite or very difficult. • Around one-third of providers had not met the required training target that 50 percent of staff should have National Vocational Qualifications, Level 2, and two-thirds of these blamed staff turnover for the shortfall. <p>Recruiting had reportedly become easier during the recession, but as retention often remained a problem, recruitment is typically a continuous and never-ending process.</p> <p>I would take staff on every week. My aim is to try and recruit two staff every week. (Manager, XD.Dom 1)</p>
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Thus, the main message from the survey data is that there are serious gaps in the supply of care staff and in their stability, which affects reaching training targets, quality standards, and the ability to cover care and meet continuity goals. The common experience of recruitment and retention difficulties is reflected in the near absence of strong correlations between the factors listed in Table II and the index of fragmented time for the sample of IDPs. There are nevertheless two significant correlations: IDPs using less of a fragmented time system are more likely to retain new recruits and less likely to put up with poor performance.

In view of these widely perceived problems of labor supply, one might expect IDPs to develop other HR policies to compensate for the negative aspects of the fragmented-time systems. Table III

presents three areas of HR policy: pay and career, staff development, and employee voice. With respect to pay and career opportunities, the IDPs perform as poorly as they do on fragmented-time practices: 70 percent pay a modal rate of pay no more than 20 percent above the NMW, and over 20 percent did not regularly upgrade pay levels. Opportunities for pay advancement were limited, as is indicated by the low modal pay rate and limited pay enhancement by skill or qualifications (often a matter of pence). Likewise, although staff do have opportunities in most IDPs to move into senior carer positions, in many cases the pay increases are minimal, only up to £1 per hour where we have data. Two pay practices correlate positively with our index of fragmented time, so that those IDPs with less fragmented time are more likely to upgrade pay regularly and to pay for criminal records checks. Figure 1 further illustrates that pay does not compensate for fragmented-time practices; there is no evidence of a downward sloping trend line of pay rates as the fragmented-time index rises.

Nevertheless, there was not a complete lack of formal HR policies in the IDPs. In contrast to working-time and pay practices, a perhaps surprisingly high percentage of IDPs used formal methods for staff development such as appraisal (69 percent offered at least an annual appraisal), and used appraisals to identify staff training needs (in 77 percent of cases). All were engaged in training (83 percent said training to National Vocational Qualification level 2⁹ was compulsory, and seven out of 11 identified courses were said to be compulsory by over 90 percent of IDPs), and over 30 percent had either achieved or were working toward an Investors in People award.¹⁰ Perhaps most surprisingly, 83 percent conducted staff attitude surveys, and 90 percent held staff meetings every three months or more frequently. However, this piecemeal application of recognized formal HR policies can be directly attributed to the external environment, as there is an increasing tendency for LAs to require IDPs to demonstrate these practices at the point of tendering (Rubery et al., 2013; Hughes et al., 2009). These commissioning requirements are reinforced by the regulatory inspection systems in England and have added to what IDPs have to demonstrate to win business without lifting the cost constraints (Cunningham, 2008). Indeed, very few LAs paid additional fees to IDPs demonstrating high-quality HR practices (only two out of the 14), but many more expected training and staff development practices to be in place and implemented.

In this commissioning context, the scope for improving practices with respect to both

TABLE III HR Practices among 52 Independent Domiciliary Care Providers and Correlation with the Fragmented Time Index

HR practice:	% of IDPs		Correlation with fragmented time index	Sample size
	Poor HR practice	Better HR practice		
Pay and career practices:				
Modal pay rate	70% pay <20% above minimum wage	30% pay >20% above minimum wage	0.224	50
Regular upgrading of pay	22% No	78% Yes	0.390**	51
Opportunities for pay improvements	73% pay an experienced worker less than 40 pence per hour more than the minimum rate	27% pay more than 40 pence for experience	-0.018	50
Payment for criminal records checks	37% do not pay; 15% only pay after staff have been in post	35% pay and 12% pay half	0.450**	51
Staff development:				
Appraisal	4% no appraisal or less frequently than annual	69% annual; 27% more frequent	-0.260*	52
Identification of training needs	23% have no system or only respond to employee request	77% appraisal only plus employee request	-0.044	52
Compulsory NVQ training	16.7%	83.3%	-0.054	52
Investors in People award	66% no award	33% hold award or are working toward it	0.016	46
Employee voice:				
Staff attitude surveys	17% no staff attitude survey	83% have staff attitude survey	-0.096	52
Staff meetings	10% have staff meetings less frequently than every three months	90% every three or more frequently (27% monthly or more frequent)	0.054	52

Note: Pearson correlation measure is significant (2-tailed) at the 0.1 level (*) and the 0.05 level (**).

fragmented time and overall pay may be limited. Moreover, high fees were no guarantee of better working-time arrangements: while two of the five IDPs with the best working time practices were located in the LA that paid exceptionally high fees, the other two from this LA had scores close to the .5 average. Nevertheless, many IDPs had limited scope to improve formal practices but still needed to find some ways to manage their staff shortages and to address the problems caused by working time. When asked about why staff left, the three most important factors cited were first more convenient working hours (33 percent), followed by family circumstances (31 percent) and low pay (21 percent).

Our data analysis suggests there were three main ways in which IDPs adapted their HR

practices to deal with fragmented-time problems: (1) by insisting on willingness to work on a fragmented-time basis at the point of recruitment; (2) by making some individualized adjustments of working time but within the overall framework of fragmented time; and (3) by using other staff (care coordinators, senior carers, or new recruits) to provide flexibility of last resort.

The first priority among IDPs was to select only those staff willing to accept flexible hours, with most making availability to work weekends or for early and late calls, or both, a requirement at recruitment. Some sought to weed out applicants who required more standard family-friendly hours.

I'd rather not allow them through the door ... because it's about a reality check.

They actually think it's what they want, but it's not functionally what they are able to do. (Manager ON.Dom 1)

Some IDPs clearly assumed care staff had a moral obligation to put their work ahead of family commitment and do "their fair share" of unsocial hours work.

Normally, the carers will take it in turns to do the evenings. ... As long as they do a couple of evenings a week and do their fair share, then that's how we tend to work it. (Manager ON.Dom 2)

Other strategies were also used. IDPs benefited from recruiting staff with high income needs, including those saving up for specific reasons, new migrants concerned for their future, or simply those struggling to make ends meet. Another strategy was to recruit more staff; this had happened in two of the eight case-study organizations

A too rapid expansion may threaten to undermine existing staff's feelings of security with respect to their income in a context of zero-hours contracts.

as recruitment constraints eased in the recession. However, a too rapid expansion may threaten to undermine existing staff's feelings of security with respect to their income in a context of zero-hours contracts. Contrary to agreements at interview, staff were not always flexible, and IDPs were often trying to find new arrangements to provide more reliable cover or that were considered fairer.

We did run alternative weekend work, but now ... staff have to work either Saturday or Sunday. Some of the extra staff only work weekends. (Manager RN.Dom 2)

There were two main ways in which IDPs made informal adjustments to their working-time practices in efforts to retain staff. First, despite the zero-hours contracts, IDPs normally did try to offer staff the volume of hours they preferred, with the caveat that the care worker still took the short-term hit if clients moved to care homes or hospital. Second, IDPs made efforts to adjust to preferred hours but within a context where the starting point was the acceptance of highly flexible and fragmented hours. This context may explain the high percentage of IDP managers who said they met employees' working hours preferences most of the time (Table I), as one IDP manager provider commented (not a case-study organization):

I think that's a tricky one because people's preferences might be working

Monday to Thursday 10 till 2, but they know that isn't an option, so it's whether people think the rotas are reasonable. ... (Manager RD.Dom 2)

Interviews with care coordinators revealed that concerted efforts were made to match work schedules to preferences:

I ... try to make sure they're in the right areas and they're not running around from here to there. (RN.Dom 1, Care Coordinator and Care Worker)

Nevertheless, accommodations for family and personal circumstances have to be understood in the social care context and IDP managers may exaggerate the extent of employee or family-friendly policies.

We normally work around things like that. I think people come into the job because it's flexible and they can work around their sort of family responsibilities. (Manager RN.Dom 1)

Due to the expected time fragmentation, care workers may be grateful for any accommodation of their specific needs, even when they themselves are providing considerable flexibility. One care worker who worked seven days a week to support a user who did not want more than one carer was very grateful for being allowed to arrange her hours to visit her sick grandmother: "They're dead flexible with me doing that" (IL.Dom 2, Care Worker 2). The situation of another care worker again illustrates the restricted accommodation to family responsibilities. One motivation for taking the job was that she could pick her children up from school, but to cover her early starts, she needed her mother to take the children to school, and to avoid weekend working she felt obliged to work some evenings until 10 p.m. and to provide holiday cover. Even so, she felt that being let off weekend working was a major favor.

Moreover, even when care workers were unhappy with some aspects of working time, the efforts made by coordinators were often appreciated: "They do actually try and give us what they can and help us out ... The ladies are lovely" (XD.Dom 1, Care Worker 2). Accommodation to an individual's needs may, however, come at the expense of the coordinator's own time as the costs of adjustment are passed on. This was found in several case studies, including the IDP with the best score on the fragmented-time index.

This week, for example, I had care every morning this week, apart from Wednesday. ... And then I get to the

office for 9, and I stay till 5. ...next week ... I have to do the office hours and then Friday night I'll have work till 8/9 o'clock. (XD.Dom2, Care Coordinator and Care Worker)

New starters may also be expected to be flexible, but this could lead to rapid turnover if they do not get the hours of work they need.

You spend, like a 15-minute call, for example, and you spend 15 minutes or half an hour either side of that call getting there and it's just that call for the day ... It's so early days. ... like I need to work a certain number of hours in a week and I can only go on for like a certain length of time, and if I'm not getting those hours then there's no point in me staying. (RN.Dom 2, Care Worker 4)

One care worker, who was finding her new job as a senior carer stressful, negotiated to drop doing the tea run in return for starting early: "So I'm in my first house at six o'clock every morning, she's been up since five. So it's fitting in fine for me to do it that way" (ON.Dom 2, Senior Care Worker). Others chose six- or seven-day schedules to maximize continuity with their users and reduce uncertainty for themselves: "I've got the same people every day, six days a week. I've got a brilliant relationship with all my people" (IL.Dom 2, Senior Care Worker).

These strategies to stabilize their own hours, even if vital to prevent burnout, still leave care staff working at the extreme ends of unsocial hours working, far away from conventional family-friendly hours. These are adjustments on the margin, with the key characteristics of fragmented time remaining intact.

In considering the final research question—why do IDPs not use more effective HR practices to address persistent staff shortages—we need to return to the issue of structure versus strategy. The key constraints on managerial agency lie in the nature of the market and the commissioning practices. Failures to recruit and retain staff or reward quality care are not necessarily punished as attention is focused on cost. Further, the commissioning environment restricts IDPs' scope to develop good HR policies through its use of time-limited, electronically monitored, and low flat-rate fees. Even local improvements in commissioning practice are not necessarily taken up by IDPs to improve the employment offer. Three factors appear important in this respect. First, there was clear evidence of rapid changes in commissioning practices linked to changes in either national or

local policies, such that response to current commissioning might be risky as conditions might quickly change (Rubery et al., 2013). Second, profit margins are reported to be low—at 2 to 3 percent, according to the employers' association,¹¹ such that additional fees might first increase profits. The third factor is the increasing role of national chains; although a minority among IDPs, they are increasing their presence among preferred providers and, according to our five national chain headquarter interviews, had adopted a policy of decentralized HR practice to enable establishments to meet local commissioning requirements. However, this flexibility appeared to be exercised more in a downward than an upward direction; in two cases, where we had matched cases across high- and low-fee-paying LAs for the same national chain, pay rates remained close to the NMW in both LAs. This lack of upward responsiveness may be due to fear of pressure to improve conditions in other LAs or to the use of higher fees in some LAs to offset low margins or losses in others (Grimshaw et al., forthcoming). The expansion of large private-sector organizations into social care may also be linked to longer-term strategies to secure a strong foothold in the UK health and social care market¹² as it becomes increasingly opened up to private-sector competition. If this is the case, the pressure on margins since the public expenditure cuts post 2010—and after our survey—may be facilitating an increasing presence of large organizations if small providers are unable to operate at a profit.

As current commissioning arrangements may limit the scope for improved pay, IDPs could be expected to turn to some working-time adjustments to secure and retain staff. The widespread findings that informal HR practices are associated with high job satisfaction in small workplaces, coupled with Atkinson and Lucas's (2013) findings for social care, would suggest that this is an important strategy for promoting satisfaction and retention. However, these adjustments are also consistent with HR strategies being at best "partial routes to failure." Not only are these individualized accommodations made within the framework of fragmented time, but our data suggest they may come at the expense of either the care coordinators' working conditions or put recent recruitment in jeopardy by placing the burden on new entrants. Informal adjustment

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may not even solve immediate staffing issues but also, and more importantly, it does not address the wider problem of how to generate new pools of potential recruits for social care to overcome the persistent labor shortage.¹³

Evidence from a range of studies (Atkinson & Lucas, 2013; McClimont & Grove, 2004; Mittal et al., 2009; Rakovski & Price-Glynn, 2010; Skills for Care, 2007; Stacey, 2005) including our own (see Hebson, Rubery & Grimshaw forthcoming) does suggest that retention in social care is assisted by the high satisfaction many staff derive from the nature of work; for example, only two of the 41 interviewed care workers expressed a desire to leave care work, and all said they derived high job satisfaction from the work itself. However,

The motivations for outsourcing are not found in the simplicity of the tasks but in the opportunities to evade collectively agreed terms and conditions and mobilize a predominantly female labor force with limited individual bargaining power.

this high job satisfaction for some is not necessarily indicative of scope to expand the labor pool. Recruitment focuses on staff willing to work very flexibly over the week and during the day, often involving frequent unpaid breaks. The persistent labor shortage indicates that this generates only a limited pool of those willing to accommodate and tolerate these working conditions, whether because they are locally based, keen to work long hours, have family support, or simply because they either have a particular interest in undertaking care work or find it more rewarding than the alternative jobs available to them (Hebson et al., forthcoming). Even under recessionary conditions, the pool of potential workers was largely insufficient and could not be readily expanded to those living outside the immediate local area. Thus, the minor working-time

adjustments represented efforts to retain existing staff within a fragmented time framework and were largely inadequate to attract and retain a wider pool of labor.

Discussion and Conclusions

This study has five main implications for the understanding of HRM as applied to sectors such as social care. These relate to (1) the conditions under which subcontracting takes place; (2) the scope for HR policies to resolve contradictions; (3) the understanding of worker engagement and commitment; (4) the framing of work-life balance policies; and (5) the debate on voluntarism versus regulation in the development of good HR practice.

The first implication is that these results in social care reinforce existing critiques (Marchington et al., 2005; Purcell, Purcell, & Tailby, 2004) of the oversimplified skill-based explanations for subcontracting, whereby only routinized tasks are outsourced on arm's-length contracts, as suggested by Lepak and Snell's (1999) HR architecture framework. In contrast, social care staff need to form relationships with users and to be able and willing to operate autonomously. Here, the motivations for outsourcing are not found in the simplicity of the tasks but in the opportunities to evade collectively agreed terms and conditions and mobilize a predominantly female labor force (Palmer & Eveline, 2012) with limited individual bargaining power. However, the outcome is not necessarily smoothly functioning supply chains, as is exemplified by the turnover and labor shortage in social care.

This leads to the second implication that there should be more recognition given to the limited scope for HR policies to resolve contradictions between business strategies and employment outcomes. Social care provides a clear case where structure dominates strategy in shaping HR practices (Barrett & Rainnie, 2002; Harney & Dundon, 2006). Where practices are amended to ease constraints, such as the informal adjustment of working time, the outcome is at best an individualized solution that may have negative repercussions on, for example, working time for new starters, thereby reinforcing retention problems. In this context, "best fit" certainly may not imply "good fit." Given the constraining commissioning process, it must be recognized, as Boxall and Purcell argue (2003, p. 35) that even though all firms enjoy some degrees of freedom, the strategic scope for IDPs is narrow and close to being determined by the external environment, certainly far away from the voluntaristic model of strategic choice. The failure of the increasingly prevalent national chains to use HR to address labor shortages may also suggest that their priorities lie in establishing a strong presence in the whole health and social care sector rather than in challenging current unsustainable costing models. Thus, not only should the scope for strategic HR not be overstated, but also it must not always be assumed that organizations are motivated to resolve their immediate HR problems.

The third implication is that the expectations and requirements placed on care staff do not fit with current HR arrangements. This article has focused on these requirements primarily in relation to working time; not only do care staff need to get out to work in the early morning, often six and sometimes seven days a week, but they also have to be willing and prepared to turn out for

work several times a day after unpaid break periods. Care staff have to tolerate a high degree of work interference in their personal and family lives as they juggle family and work demands through the waking day. This does not fit a simple model where engaged and reliable workers are needed only in organizations adopting high-performance workplace practices and sophisticated psychological contract tools. Furthermore, the vulnerability of users and the high autonomy of staff who often work alone means that the maintenance of a quality and safe service is dependent on reliable and responsible staff. This requirement for commitment is demonstrated by a 2013 Department of Health-led initiative to ask employers and their employees to sign up to the Social Care Commitment,¹⁴ which asks employers for appropriate training and supervision of care staff and for individual care staff to commit to working responsibly, upholding dignity, working cooperatively, communicating effectively, protecting privacy, continuing to learn, and treating people fairly. These expectations of workforce behavior are being promoted in a context in which employment conditions at best tend to match the national minimum wage (Bessa et al., 2013; HM Revenue & Customs [HMRC], 2013). Future HRM research might, therefore, usefully extend the exploration of worker engagement and commitment beyond the types of firms where requirements for commitment can be expected to be matched by supportive HR policies.

A fourth implication from this study is that the now frequently discussed work-life balance policies need to be interpreted, as Fleetwood (2007) has argued, against the background of working-time practices that increase conflict with private and family life. Where employees expect to be asked to work whenever required, moderation of these requirements by HR managers may induce positive responses from their staff. Such modifications must not be confused with practices that “balance” work and private life as they start from highly unbalanced positions. Our study also reveals that what constitutes a feasible work-life arrangement for one individual may deviate quite significantly from others’ preferred arrangements. Tailored as well as general working-time adjustment models may be required, particularly where time constraints on delivery are as severe as in social care.

The fifth implication from this study is that in deregulated sectors and economies, regulation may need to play a stronger role in improving HR outcomes as voluntary employer action, often the expected and preferred method within the HR literature, is not forthcoming. This may reflect

constraints within the supply chain or managers’ reluctance to cede control, even if the exercise of this control—for example, through zero-hours contracts—also contributes to labor shortage and turnover. Regulation may be the only way to demonstrate to employers in social care that guaranteed hours and minimum shift periods are vital for extending the labor pool. The providers’ partial routes to failure are leading to a collective macro failure to provide adequate adult social care in England. Current practices rely on care staff’s goodwill to work more hours than they are paid for even when their hourly pay rate is already close to the minimum wage, to fund their own travel, and to constantly reschedule their times to maintain earnings. Voluntary solutions to problems of care quality such as the social care commitment code are unlikely to expand the pool from which stable employees can be recruited. This failure of voluntary solutions may need to be more emphasized by HR scholars and practitioners before political parties accept that regulation must be extended.

Finally, this study has various limitations. It is a one-country study in a deregulated labor market but where social care is still mainly publicly funded. Although one can anticipate some convergence of social care systems, the specific institutional conditions under which social care is organized will remain nationally specific. This English case study nevertheless provides a warning to policymakers responsible for managing services that stretch over the whole day and week. It highlights the tensions that can be expected to arise if attention is not paid to converting these service delivery arrangements into sustainable employment. Likewise, this study has highlighted the neglect of working time as an HR policy and suggests that it should be included as a core element in future HR research.

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Notes

1. Information is from interviews with HR managers at five national chains.
2. One or two salient comments from other providers in the telephone survey are also included.
3. Scores for binary indicators are either low or high, while the four-level indicator (premiums for unsocial hours and overtime) has scores of 0, .33, .67, and 1.
4. The Transfer of Undertakings Protection of Employment (TUPE) legislation protects certain employment conditions of workers transferred from one employer to another through, for example, outsourcing.
5. "Mithering" is a dialect word meaning bother.
6. This is based on 51 IDPs due to missing data.
7. Twenty-three out of 35 IDPs set a minimum visit time of 15 minutes or less (17 missing).
8. That is two carers for a one-hour visit.
9. NVQ level 2 is regarded as equivalent to a pass at grades A to C of the age 16 school qualification GCSE. It is based on accreditation of displayed competence at the workplace.
10. Investors in People is a business improvement tool administered by the UK Commission for Employment and Skills. It was launched in 1991 (<http://www.investorsinpeople.co.uk/>).
11. This is from UK Home Care Association (UKHCA), quoted at <http://www.communitycare.co.uk/2013/03/22/providers-cannot-increase-pay-for-home-care-workers-at-time-of-council-cuts/>
12. Since 2010 there have been further moves to integrate health and social care commissioning.
13. Migrant workers have been used to fill labor shortages, particularly in London and the Southeast (Rubery et al., 2011).
14. See <https://www.thesocialcarecommitment.org.uk/>

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